CONTRACT

BETWEEN

**SOUTH CAROLINA** 

DEPARTMENT OF HEALTH AND HUMAN SERVICES

AND

MHN PROVIDER

FOR THE PURCHASE AND PROVISION OF

THE DEVELOPMENT AND MAINTENANCE OF

MEDICAL HOMES NETWORK

**UNDER THE SOUTH CAROLINA MEDICAID PROGRAM** 

**DATED AS OF** 

**April 1, 2008** 

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This Contract is entered into as of the first day of April 2008, by and between the South Carolina Department of Health and Human Services, Post Office Box 8206, 1801 Main Street, Columbia, South Carolina, 29202-8206, hereinafter referred to as "SCDHHS" and MHN Provider (hereinafter referred to as "Contractor").

#### RECITALS

WHEREAS, SCDHHS is the single state agency responsible for the administration in South Carolina of a program of Medical Assistance under Title XIX of the Social Security Act.

WHEREAS, the United States Department of Health and Human Services has allocated funds under Title XIX of the Social Security Act to SCDHHS for the Development of Medical Homes Networks.

WHEREAS, the Contractor represents and warrants that it meets applicable standards as a Contractor of the Development of Medical Homes Networks Services as specified by Title XIX of the Social Security Act, federal regulations promulgated pursuant thereto, and the South Carolina State Plan for Medical Assistance.

WHEREAS, the Contractor desires to participate in the provision of the Development of Medical Homes Networks Services under Title XIX of the Social Security Act.

NOW, THEREFORE, the parties to this contract, in consideration of the mutual promises, covenants, and stipulations set forth herein, agree as follows:

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#### 1 GENERAL PROVISIONS

#### 1.1 Effective Date and Term

This Contract and its appendices, hereby incorporated, contain all of the terms and conditions agreed upon by the parties. All terms and conditions stated herein are subject to prior approval by CMS. To ensure the availability of Federal Financial Participation (FFP) for the entire contract period, this Contract must be submitted to CMS for prior approval at least forty-five (45) calendar days in advance of the proposed effective date. This Contract shall be effective no earlier than the date it has been approved by CMS, and signed by the Contractor and SCDHHS, and shall continue in full force and effect from April 1, 2008 until March 31, 2010 unless terminated prior to that date by provisions of this Contract. The documents referenced in this Contract are on file with the Contractor and with SCDHHS, and the Contractor is aware of their content.

### 1.2 Notices

Whenever notice of contract termination or amendment is required to be given to the other party, it shall be made in writing and delivered to that party. Delivery shall be deemed to have occurred if made in person and a signed receipt is obtained or three (3) calendar days have elapsed after posting if sent by registered or certified mail, return receipt requested. Notices shall be addressed as follows:

In case of notice to Contractor: MHN Provider 100 North Avenue Anywhere, SC 29001

In case of notice to SCDHHS:

South Carolina Department of Health and Human Services 1801 Main Street Post Office Box 8206 Columbia, South Carolina 29202-8206

cc: Chief, Bureau of Care Management and Medical Support Services Chief, Bureau of Administrative Services

SPES

Said notices shall become effective on the date specified within the notice. Either party may change its address for notification purposes by mailing a notice stating the change, effective date of change and setting forth the new address. If different representatives are designated after execution of this Contract, notice of the new representative will be rendered in writing to the other party and attached to originals of this Contract.

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#### 1.3 Definitions

The terms used in this Contract shall be construed and/or interpreted in accordance with the definitions set forth as follows:

Action – A termination, suspension or reduction (which includes denial of a service based on Office of General Counsel interpretation of CFR 431) of Medicaid eligibility or covered services. It further means determinations by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a State with regard to the preadmission screening and annual resident review requirements of section 1919(e)(7) of the Act.

<u>Beneficiary</u> - A person determined eligible to receive services as provided for in the South Carolina State Plan for Medical Assistance (interchangeable with the term Recipient).

<u>Care Coordination Services Organization (CSO)</u> - Experienced, responsive, responsible, and financially sound organizations that provide administrative support to the Medical Homes Network and the participating primary care practices. The CSO shall serve as the designated agent for the Medical Homes Network

<u>Care Coordination</u> – Activities performed by the Network on behalf of the members to coordinate and monitor their treatment and improve the cost/benefit of services delivered.

<u>Care Coordination Fee</u>- The amount paid to the Contractor per member per month for each MEDICAL HOMES beneficiary who has chosen or has been assigned to the Contractor.

C.F.R- Code of Federal Regulations.

CMS: Centers for Medicare and Medicaid Services.

<u>Cold Call Marketing</u>: Any unsolicited personal contact by the PCCM with a potential member for the purpose of marketing.

<u>Disease Management</u>: Activities performed on behalf of the members to coordinate and monitor their treatment for specific identified chronic diseases and educate the member to maximize appropriate self-management.

<u>Documented Cost Savings</u> – Those cost savings verified by SCDHHS by using an independent actuary to establish the baseline and to conduct periodic reconciliation during the Contract period. The difference between

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the Medicaid Upper Payment Limit of the Medical Homes Network enrollees as defined/calculated in Appendix B of the Contract and the total amount of covered claim expenditures incurred by Medical Homes Network enrollees (including the prospective per member per month case management/care coordination fee payments) during the contract period.

<u>Eligible Beneficiary</u>: Individuals who have been deemed eligible for Medicaid and may be enrolled in the MEDICAL HOMES program.

<u>Enrollee</u> – A Medicaid beneficiary who is currently enrolled in an MCO, PIHP, PAHP, or PCCM in a given managed care program.

<u>FFP (Federal Financial Participation)</u>: Any funds, either title or grant, from the Federal Government.

GAO: General Accounting Office.

Group Practice/Center: A Medicaid participating primary care provider structured as a group practice/center which (1) is a legal entity (e.g., corporation, partnership, etc.), (2) possesses a federal tax identification (employer) number, and (3) is designated as a group by means of a Medicaid Group Provider number.

HIPAA: Health Insurance Portability and Accountability Act of 1996.

Managed Care Organization – An entity that has, or is seeking to qualify for, a comprehensive risk contract that is—(1) A Federally qualified HMO that meets the advance directive requirements of subpart I of 42CFR § 489; or (2) Any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions: (a) Makes the services it provides to its Medicaid members as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid recipients within the area service by the entity; and (b) Meets the solvency standards of 42CFR §438.116. This includes any of the entity's employees, affiliated providers, agents, or contractors.

<u>Managed Care Plan</u> - The term "Managed Care Plan" is interchangeable with the terms "Contractor", "Plan", or "HMO/MCO".

<u>Marketing</u>: Any communication from a MHN to a Medicaid beneficiary who is not enrolled in that entity, that can reasonably be interpreted as intended to influence the beneficiary to enroll in that particular MHN's Medicaid product, or either to not enroll in, or to disenroll from, another Medicaid product.

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Marketing Materials: Materials that are produced in any medium, by or on behalf of a PCCM and can reasonably be interpreted as intended to market to potential members.

Medical Homes Network: A group of physicians, who are enrolled as Primary Care Case Management (PCCM) providers, any advisory boards, and the Care Coordination Services Organization that provides the infrastructure for the group which accepts the responsibility for providing medical homes for members and for managing members' care.

MEDICAL HOMES Program Policy: All policies and procedures required by this agreement and incorporated herein by reference are published in the MEDICAL HOMES Policy and Procedure Guide.

Member: A Medicaid beneficiary who chooses (or is assigned) to a **MEDICAL HOMES NETWORK** primary care provider.

<u>Member Disenrollment</u>- The deletion of the individual from the monthly list of members furnished by the SCDHHS to the Contractor.

NPI: National Provider Identifier

<u>Outcomes</u> – Performance measures designed to evaluate the implementation and accomplishment of the MHN providers and the Contractor.

Ownership Interest: The possession of stock, equity in the capital, or any interest in the profits of the Contractor. For further definition see 42 CFR 455.101 (2004, as amended).

<u>Patient Care Coordination</u>: The manner or practice of providing, directing, and coordinating the health care and utilization of health care services of members with regard to those services as defined by MEDICAL HOMES Policy that must be authorized by the primary care provider. If not provided directly, necessary medical services must be arranged through the primary care provider.

<u>Pharmacy Management</u> – Activities designed to monitor and oversee the utilization of medications, prescribed and over-the-counter, by both the Member and the Provider, to improve the cost/benefit of the use of pharmaceuticals.

<u>Policies</u>: The general principles by which SCDHHS is guided in its management of the Title XIX program, as further defined by SCDHHS promulgations and by state and federal rules and regulations.

<u>Potential Enrollee</u>: A Medicaid beneficiary who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet a member of a specific Primary Care Provider.

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<u>Preventive Services</u>- Services rendered for the prevention of disease in adults and children as defined by MEDICAL HOMES Policy.

<u>Primary Care-</u> The ongoing responsibility for directly providing medical care (including diagnosis and/or treatment) to a member regardless of the presence or absence of disease. It includes health promotion, identification of individuals at risk, early detection of serious disease, management of acute emergencies, rendering continuous care to chronically ill patients, and referring the member to another provider when necessary.

<u>Primary Care Case Management (PCCM)</u>: A system under which a Primary Care Case Manager contracts with the State to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid beneficiaries.

Primary Care Provider (PCP): The participating physician, physician extender (PA, FNP, CNM), or group practice/center selected by or assigned to the member to manage, provide and coordinate all of the member's health care needs; to initiate and monitor referrals for specialized services when required; to contribute to the development and implementation of the care treatment plan, and participate in quality of care initiatives and reviews.

<u>Program</u>: The method of provision of Title XIX services to South Carolina beneficiaries as provided for in the South Carolina State Plan for Medical Assistance and SCDHHS regulations.

<u>Provider Education</u> – Information and training on, at a minimum, evidence-based medicine and Best Practice protocols delivered to the MHN providers.

Recipient: A person determined eligible to receive services as provided for in the South Carolina State Plan for Medical Assistance (interchangeable with the term Beneficiary).

Social Security Act: Title 42, United States Code, Chapter 7, as amended.

<u>Social Services</u>: Medical assistance, rehabilitation, and other services defined by Title XIX, USDHHS regulations, and SCDHHS regulations.

SCDHHS: South Carolina Department of Health and Human Services.

<u>SCDHHS Appeal Regulations</u>: Regulations promulgated in accordance with the S.C. Code Ann. §44-6-90 at S.C. Code Regs. 126-150 <u>et seq.</u> and S.C. Code Ann. §§1-23-310 <u>et seq.</u> (1976, as amended).

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<u>South Carolina State Plan for Medical Assistance</u>: A plan, approved by the Secretary of USDHHS, which complies with 42 U.S.C.A. Section 1396a, and provides for the methodology of furnishing services to beneficiaries pursuant to Title XIX.

<u>Title XIX</u>: Title 42, <u>United States Code</u>, Chapter 7, subchapter XIX, as amended. (42 U.S.C.A. Section 1396 et seq.)

<u>USDHHS</u>: United States Department of Health and Human Services.

# 1.4 Entire Agreement

The Contractor shall comply with all the provisions of the Contract, including amendments and appendices, and shall act in good faith in the performance of the provisions of said Contract. The Contractor shall be bound by Medicaid policy as stated in applicable provider manuals and in the Medical Homes Network Policy and Procedure Guide. The Contractor agrees that failure to comply with the provisions of this Contract may result in the assessment of liquidated damages, sanctions and/or termination of the Contract in whole or in part, as set forth in this Contract. The Contractor shall comply with all applicable SCDHHS policies and procedures in effect throughout the duration of this Contract period. The Contractor shall comply with all SCDHHS handbooks, bulletins and manuals relating to the provision of services under this Contract. Where the provisions of the Contract differ from the requirements set forth in the handbooks and/or manuals, then the Contract provisions shall control.

SCDHHS, at its discretion, will issue Medicaid bulletins to inform the Contractor of changes in policies and procedures which may affect this Contract. The SCDHHS is the only party to this Contract which may issue Medicaid bulletins.

# 1.5 <u>Federal Approval of Contract</u>

The CMS Regional Office shall review and approve all MHN contracts, including those risk and nonrisk contracts that, on the basis of their value, are not subject to the prior approval requirements in §438.806. The CMS has final authority to approve this contract between SCDHHS and the Contractor in which payment hereunder shall exceed one hundred thousand dollars (\$100,000.00). If CMS does not approve this Contract entered into under the Terms & Conditions described herein, the Contract will be considered null and void.

### 1.6 Extension & Renegotiation

This Contract may be extended for a period which may be less than but not exceed one (1) year beyond the initial contract term whenever either of the parties hereto provide the other party with ninety (90) calendar days advance notice of intent to extend and written agreement to extend the Contract is obtained from both parties. Any rate adjustment(s) shall be set

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forth in writing and signed by both parties. Either party may decline to extend this Contract for any reason. The parties expressly agree there is no property right in this Contract. This contract may be renegotiated for good cause, only at the end of the contract period, and for modification(s) during the contract period, if circumstances warrant, at the discretion of the State.

### 1.7 Amendments

This Contract may be amended at anytime as provided in this paragraph. This Contract may be amended whenever required to comply with state and federal requirements. No modification or change of any provision of the Contract shall be made or construed to have been made unless such modification is mutually agreed to in writing by the Contractor and SCDHHS, and incorporated as a written amendment to this Contract prior to the effective date of such modification or change. Any amendment to this Contract shall require prior approval by SCDHHS, CMS, and CMS Regional Office prior to its implementation.

#### 2 FINANCIAL AND PLAN MANAGEMENT

The Contractor shall be responsible for sound fiscal management of the health care plan developed under this Contract. The Contractor shall adhere to the minimum guidelines outlined below.

# 2.1 Per Member Per Month Care Coordination Payments

The Contractor agrees to accept the prospective Per Member Per Month (PMPM) Care Coordination payments remitted by SCDHHS to the Contractor as payment in full for all services provided to Medicaid MHN Program members pursuant to this Contract. The PMPM payment is equal to the monthly number of members multiplied by the established rate. This does not preclude SCDHHS from offering the contractor financial incentives as described in Section 12.2 of this contract.

### 2.2 Co-payments

No copayments shall be charged to any Medicaid MHN Program member(adult or child) for any service or product covered under the Medicaid program.

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# 2.3 Return of Funds

The Contractor agrees that all amounts identified as being owed to SCDHHS are due immediately upon notification to the Contractor by SCDHHS unless otherwise authorized in writing by SCDHHS. SCDHHS, at its discretion, reserves the right to collect amounts due by withholding future PMPM payments. SCDHHS reserves the right to collect interest on unpaid balances beginning thirty (30) calendar days from the date of initial notification. The rate of interest charged will be the same as that fixed by the Secretary of the United States Treasury as provided for in 45 CFR 30.13. This rate may be revised quarterly by the Secretary of the Treasury and shall be published by HHS in the Federal Register.

In addition, the Contractor shall reimburse SCDHHS for any federal disallowances or sanctions imposed on SCDHHS as a result of the Contractor's failure to abide by the terms of the Contract. The Contractor will be subject to any additional conditions or restrictions placed on SCDHHS by the United States Department of Health and Human Services (HHS) as a result of the disallowance. Payments of funds being returned to SCDHHS shall be submitted to:

South Carolina Department of Health and Human Services
Department of Receivables
Post Office Box 8355
Columbia, South Carolina 29202-8355

# 2.4 Third Party Liability (TPL)

If applicable, the Contractor must make all reasonable efforts to collect from any health insurance policy, which covers a Medicaid beneficiary. Any payment from the insurance company must be shown on the Medicaid claim when submitted to SCDHHS or refunded to SCDHHS up to the amount of the payment if already paid. The Contractor shall further contact the Director of Third Party Liability, SCDHHS, if contacted by an attorney for claim information and medical records concerning a Medicaid beneficiary. SCDHHS shall be advised in writing by the Contractor upon receipt, or the potential for receipt, of any income or resources for the beneficiary from any third party payor within ten (10) calendar days of the Contractor acquiring knowledge of such income or resources. SCDHHS or its designee shall have full access to financial records to determine if the third party collections have been refunded to Medicaid in accordance with this Section. Failure by the Contractor to collect available third party payments may result in recoupment of these payments by SCDHHS.

2.4.1 SCDHHS will share data with the Contractor regarding any insurance coverage it discovers for any covered Medicaid MHN Program member. While SCDHHS will make reasonable efforts to ensure that the shared data is accurate, SCDHHS cannot guarantee the accuracy of the data.

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- 2.4.2 When the Contractor has determined that other insurance coverage exists for which the SCDHHS has not shared data with the Contractor already, the Contractor shall notify SCDHHS of this coverage.
- 2.4.3 If a Medicaid MHN Program member refuses to cooperate with the Contractor in pursuit of other liable parties, the Contractor will request the assistance of SCDHHS.

### 2.5 <u>Training</u>

The Contractor shall be responsible for training all of its employees and network providers, and subcontractors to ensure that they adhere to the Medicaid MHN Program policies and procedures and Medicaid regulations. The Contractor shall be responsible for conducting ongoing training on Medicaid MHN Program policies and distribution of updates for its network providers/subcontractors. SCDHHS reserves the right to attend any and all training programs and seminars conducted by the Contractor. The Contractor shall provide SCDHHS a list of the training dates, time and location, at least fifteen (15) calendar days prior to the actual date of training.

### 2.6 Liaisons

The Contractor shall designate an employee of its' administrative staff to act as liaison between the Contractor and SCDHHS for the duration of the Contract. SCDHHS's Department of Managed Care will be the Contractor's point of contact and shall receive all inquiries regarding this Contract and all required reports unless otherwise specified in this Contract. The Contractor shall also designate a member of its senior management who shall act as a liaison between the Contractor's senior management and SCDHHS when such communication is required.

If different representatives are designated after execution of this Contract, notice of the new representative shall be rendered in writing to the other party.

### 2.7 Material Changes

The Contractor shall notify SCDHHS immediately of all material changes affecting the delivery of care or the administration of its health care plan under this Contract. Material changes include, but are not limited to, changes in: composition of the provider network, subcontractor network, Contractor's complaint and grievance procedures; health care delivery systems, services, changes to expanded services; benefits; geographic service area or payments; enrollment of a new population; procedures for obtaining access to or approval for health care services; and the Contractor's ability to meet enrollment levels. In addition, all changes, as required under S.C. Code Ann. §38-33-30(c)(Supp. 2000, as amended), must be approved in writing by SCDHHS and copy of appropriate changes shall be issued to Medicaid MHN Program members prior to

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implementation of the change as required under S.C. Code Ann § 38-33-30(c)(Supp. 2000, as amended), at least 30 days before the intended effective date of the change. SCDHHS shall make the final determination as to whether a change is material.

#### 2.8 Incentive Plans

The Contractor's incentive plans or its network providers/subcontractors shall be in compliance with 42 CFR 434 (2005, as amended), 42 CFR 417.479 (2005, as amended), 42 CFR 422.208 and 42 CFR 422.210 (see **MHN Policy and Procedure Guide**). The Contractor shall submit any information regarding incentives as may be required by SCDHHS.

### 2.9 Notification of Legal Action

The Contractor shall give SCDHHS immediate notification in writing by certified mail of any administrative legal action or complaint filed and prompt notice of any claim made against the Contractor by a subcontractor or member which may result in litigation related in any way to this Contract with SCDHHS.

### 2.10 Cost Report

The Contractor is required to submit an original and one copy of an actual cost report to include actual cost and service delivery information. DHHS Form 137 must be completed and mailed to SCDHHS within ninety (90) days after the contract expires or within ninety (90) days after the end of the Contractor's fiscal year if the contract is written for a period greater than one year. The cost report shall be mailed to:

Division of Ancillary Reimbursements
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206.

### 2.11 Business Relationships

The Contractor shall provide SCDHHS with full and complete information on the identity of each person or corporation with an ownership of controlling interest (5%+) in the plan, or any subcontractor in which Contactor has 5% or more ownership interest. This information shall be provided to SCDHHS on the approved Disclosure Form and whenever changes in ownership occur.

#### 2.12 Excluded Parties

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The Contractor shall be responsible for checking the Excluded Parties List Service, that is administered by the General Services Administration, when it enrolls any provider or subcontractor, to ensure that it does not employ individuals who are debarred, suspended, or otherwise excluded from participating in Federal procurement activities and/or have an employment, consulting, or other agreement with debarred individuals for the provision of items and services that are significant to the MCE's contractual obligation. The Contractor shall also report to SCDHHS any network providers or subcontractors that have been debarred, suspended, and/or excluded from participation in Medicaid, Medicare, or any other federal program.

#### 3 SCDHHS CONTRACT MANAGEMENT RESPONSIBILITIES

For and in consideration of the promises herein made by the Contractor, SCDHHS agrees to the following:

- 3.1 SCDHHS will provide the Contractor with a monthly list of members for the purpose of managing their health care needs.
- 3.2 SCDHHS will provide training and technical assistance regarding the MEDICAL HOMES program, as necessary.
- 3.3 SCDHHS will provide the MHN Policy and Procedure Guide.
- 3.4 SCDHHS will provide the Network with the **MEDICAL HOMES Medicaid Managed Care Beneficiary Handbook**, in both English and Spanish, that contains program information including member rights and protections, program advantages, member responsibilities, complaint and grievance instructions for distribution to all members and potential members.
- 3.5 SCDHHS will notify members in writing of any significant change in the **MEDICAL HOMES** Program.
- 3.6 SCDHHS will make a good faith effort to notify members in writing of the termination of a contracted Contractor within fifteen (15) days after receipt or issuance of the termination notice.
- 3.7 SCDHHS will assign each MHN a unique identifier. The current practice and/or Provider number assigned to member practices/physicians shall serve as the unique identifier for the member practices.
- 3.8 SCDHHS will work with the Network to determine information necessary to manage members' care and provide information that is feasible.

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3.8 SCDHHS will work with the Network (the Care Coordination Services Organization and any governing/advisory Board) to establish outcome measures for each year of the contract.

#### 4 SCOPE OF SERVICES

The Contractor shall possess the expertise and resources to ensure the delivery of quality health care services to Medicaid MHN Program members in accordance with the Medicaid program standards and the prevailing medical community standards. The Contractor shall adopt practice guidelines that:

- Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field
- Consider the needs of the members.
- Are adopted in consultation with contracting health care professionals.
- Are reviewed and updated periodically as appropriate.

The Contractor shall disseminate the guidelines to all affected providers and, upon request, to members and potential members. Decisions for utilization management, member education, coverage of services and other areas to which guidelines apply are consistent with the guidelines.

The Contractor's approved application is incorporated herein by reference as if stated fully herein. Any changes to approved protocols and cost-sharing methodology must be approved by SCDHHS. The Contractor must comply with all the terms and conditions contained in the **Medical Homes Network** Standards, which are incorporated herein and attached to this contract as Appendix A.

4.1 <u>Components and Core Services of the South Carolina Medicaid MHN Program</u>

The Contractor shall be responsible for the following components and core services:

- 4.1.1 In conjunction with the Network's Board of Directors and/or any Advisory Board, establishing best practices.
- 4.1.2 Monitoring overall quality of care within the Network.
- 4.1.3 Monitoring overall Network costs to Medicaid.
- 4.1.4 Utilization of data management to improve healthcare for Network members and for the State.
- 4.1.5 Formal Care Coordination and Case Management.
- 4.1.6 Service Utilization Management and tracking of services provided to members.

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- 4.1.7 Member Education.
- 4.1.8 Disease Management.
- 4.1.9 Provider Education and Training on evidence-based medicine and Best Practice Protocols.
- 4.1.10 Provider Education and Training on use of Care Coordination/Case Management, Prior Authorization procedures, Enrollment/Disenrollment, etc. with member practices and Network referral partners.
- 4.1.11 Pharmacy Management to include, but not limited to, Benefit Management Oversight, and Clinical Risk Identification.
- 4.1.12 Exception and performance tracking and reporting.
- 4.1.13 Outcomes measurement and data feedback.
- 4.1.14 Distribution of any Per Member Per Month care coordination fee to the participating physicians using an incentive-based formula.
- 4.1.15 Distribution of any cost savings.

### 4.2 Required Functions

The Contractor agrees to perform the following functions:

- 4.2.1 Recruit, screen and approve practices for participation. Screening will include, but not be limited to, verifying that potential participating provider practices have not been excluded from participating in Medicaid, Medicare, and/or SCHIP. Federal Financial Participation (FFP) is not available for reimbursement to providers excluded by Medicare, Medicaid or SCHIP except for emergency services.
- 4.2.2 Assure that participating practices meet the participation criteria as outlined below and in the **MHN Policy and Procedure Guide**:
  - 4.2.2.1 The practices must provide primary care and patient care coordination services to each member.
  - 4.2.2.2 The practices must provide or arrange for Primary Care coverage for services, consultation or referral, and treatment for emergency medical conditions, twenty-four (24) hours per day, seven (7) days per week.
  - 4.2.2.3 There must be prompt (within one hour) access to a qualified medical practitioner who is able to provide medical advice, consultation, and authorization for service

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- when appropriate. PCPs must have at least one telephone line that is answered by office staff during regular office hours. (Use of an automated system to answer the phone is acceptable as long as patients are able to access a live person through one of the automated options.)
- 4.2.2.4 PCPs must provide members with an after-hours telephone number. The after-hours number may be the PCP's home telephone number, an answering service, etc. The after-hours telephone number must be listed in the member's handbook. Changes to the after hours number should be reported to the Care Coordination Services Organization.
- 4.2.2.5 The practices must provide preventive services as defined by the network.
- 4.2.2.6 The practices must offer general patient education services to all members and potential members as well as disease management services to members for whom the services are appropriate.
- 4.2.2.7 MHN PCPs must establish and maintain hospital admitting privileges or enter into an arrangement with another physician or group practice for the management of inpatient hospital admissions of MHN members.
- 4.2.2.8 The practices will assist the member by providing systematic, coordinated care and will be responsible for all referrals for additional medically necessary care to other health care providers to ensure that services under the contract can be furnished to enrollees promptly and without compromise to the quality of care.
- 4.2.2.9 The practices will be required to follow the recommended Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screening and immunization schedules, as required by the Centers for Medicare and Medicaid Services (CMS), Centers for Disease Control (CDC) and the American Academy of Pediatrics (AAP).
- 4.2.3 Ensure that participating practices follow agreed-upon criteria for enrolling Medicaid eligible beneficiaries in the Medical Homes program as outlined in the **MHN Policy and Procedure Guide**.
- 4.2.4 Provide management of the medical and health care needs of members to assure that all medically necessary services are made available in a timely and cost efficient/effective manner.
- 4.2.5 Establish patient care coordination services to members of the **MEDICAL HOMES** Program.

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- 4.2.6 Establish a plan to ensure regular evening and weekend hours within the Network to accommodate the needs of the members.
- 4.2.7 Develop a plan to enroll Medicaid patients who do not already have a medical home with network physicians. Priority will be given to patients who use the Emergency Room for non-emergency care.
- 4.2.8 Determine the priorities for disease management, patient education and care coordination that ensure these management services are provided. Patient education topics shall include, but not be limited to, child development, childhood diseases, diabetes, high blood pressure, and other chronic diseases.
- 4.2.9 Ensure that enrollees receive all information regarding their membership in the Network within a reasonable time after the Contractor received notice of enrollment.
- 4.2.10 Ensure that all materials designed for members' use easily understood language and formats. Ensure that members receive notification that information is available in alternative formats and how to access them. Written material will be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.
- 4.2.11 Ensure that interpretive services related to health care issues are provided, as needed, to the members. Make oral interpretation services available free of charge to each potential member and existing member. This applies to all non-English languages. Ensure that members receive notification of the availability of these services and how to access them.
- 4.2.12 Conduct Marketing activities in accordance with §7 of this Contract and in the MHN Policies and Procedures Guide.
- 4.2.13 Ensure that the enrollment and disenrollment of beneficiaries is conducted in accordance with §6 of this Contract and the MHN Policy and Procedure Guide.
- 4.2.14 Work with SCDHHS to establish outcome measures for each year of the contract.
- 4.2.15 The Contractor shall agree to external quality evaluation, review of quality assessment and performance improvement (QAPI) meeting

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- minutes and annual medical audits by DHHS' External Quality Review Organization (EQRO) in accordance with standards contained in the **MHN Policy and Procedure Guide**.
- 4.2.16 Demonstrate budget neutrality or costs savings for services to beneficiaries in the plan.
- 4.2.17 Implement and operate an Information Technology System that meets the SCDHHS Information Technology standards for MHN programs.
- 4.2.18 Establish a Board of Directors or Advisory Boards that are geographically/regionally based to ensure that meetings are equally accessible to all Network practices.
- 4.2.19 Insure that individually identifiable health information must be protected in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- 4.2.20 The Contractor shall provide each member and potential enrollee with clear, accurate and truthful information (oral and written) about the Contractor's health plan to ensure that the potential enrollee received the information necessary to make an informed decision on enrollment and to ensure compliance with this Contract and with state and federal laws and regulations. The Contractor shall be responsible for developing and distributing its own member specific marketing, and educational materials. The Contractor shall not cause or knowingly permit the use of advertising, which is untrue, misleading or deceptive. The information must include a statement that enrollment in the Contractor's Plan by a Medicaid applicant/eligible shall be voluntary. The Contractor shall inform the members that enrollment shall be for a period of twelve (12) months contingent upon their continued Medicaid eligibility and that the member may request disenrollment without cause at any time during the 90 days following the date of the member's initial enrollment with the MHN.
- 4.2.21 All written material shall be written at a grade level no higher than the fourth (4th) grade, or as determined appropriate by SCDHHS. The Contractor shall ensure that where ten percent (10%) of the resident population of a county is non-English speaking and speaks a specific foreign language, materials shall be made available in that specific language to assure a reasonable chance for all potential members to make an informed choice of managed care

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plans. All beneficiary-related materials must be made available in Spanish and must be certified by a translation service.

### 4.3 Emergency Medical Services

The Contractor shall insure that emergency and post-stabilization services be rendered without the requirement of prior authorization of any kind; and shall advise all Medicaid MHN Program members of the provisions governing the use of emergency services. The Contractor shall not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. The Contractor shall submit for prior approval by SCDHHS, a copy of its written emergency services definitions and any protocols.

### 4.4 Medical Services for Special Populations

The Contractor shall implement mechanisms to assess each member identified by the State and identified to the Contractor by the State as having special health care needs in order to identify any ongoing special condition of the member that requires a course of treatment or regular care monitoring. The assessment mechanism must use appropriate health care professionals. The Contractor must have a mechanism in place to allow members to directly access a specialist as appropriate for the member's condition and identified needs (for example, through the standard referral or an approved number of visits).

The Contractor shall determine the need for any enhanced services that may be necessary for these populations to maintain their health and well being. **MHN Policy and Procedure Guide** outlines the best practices and procedures that the Title XIX SC State Medicaid Plan uses to serve the designated special populations.

Children with chronic/complex health care needs and all infants of highrisk mothers are defined as special populations in the Title XIX SC State Medicaid Plan. The special populations are identified as individuals that may require additional health care services that should be incorporated into a health management plan which guarantees that the most appropriate level of care is provided for these individuals

### 4.5 Care Coordination

The Contractor shall ensure that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member. The Contractor shall be responsible for the planning, directing and coordinating of health care needs and services for Medicaid MHN Program members in conjunction with the Primacy Care Physician through care coordination, increased accessibility of services and promoting prevention. The Contractor's care

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coordination and referral activities should incorporate and identify appropriate methods of assessment and referral for Members.

### 4.5.1 Continuity of Care

The Contractor shall develop and maintain effective continuity of care activities which seek to ensure a continuum approach to treating and providing health care services to Medicaid MHN Program members. In addition to ensuring appropriate referrals, monitoring, and follow-up to providers within the network, the Contractor shall ensure appropriate linkage and interaction with providers. The Contractor's continuity of care activities should seek to provide processes by which Medicaid MHN Program members and provider interactions can effectively occur and identify and address problems when those interactions are not effective or do not occur.

In order to provide a continuum approach to managing the needs of the member, the Contractor shall provide effective continuity of care activities that seek to ensure that the appropriate personnel, including the Primary Care Provider, are kept informed of the member's treatment needs, changes, progress or problems. The Contractor shall ensure that service delivery is properly monitored to identify and overcome barriers to primary and preventive care that the Medicaid MHN Program member may encounter.

The Contractor shall honor any prior authorization for ongoing covered Medicaid services to a Medicaid MHN Program member until the Contractor's primary care provider assigned to that member reviews the member's treatment plan.

### 4.5.2 School-Based Services

School-based services are those Medicaid services provided in school districts to Medicaid eligible children under the age of 21. The Contractor shall at a minimum have written procedures for promptly transferring medical and developmental data needed for coordinating ongoing care with school-based services.

#### 4.5.3 Women, Infant, and Children (WIC) Program Referral

The Contractor shall be responsible for ensuring that coordination exists between the WIC Program and network providers. Coordination shall include referral of potentially eligible women, infants and children and reporting of appropriate medical information to the WIC Program. The South Carolina Department of Health & Environmental Control (DHEC) administers the WIC Program. A sample referral/release of information form is found in **MHN Policy and Procedure Guide**, WIC Referral Form.

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# 4.6 <u>Family Planning and Communicable Disease Services</u>

### 4.6.1 Family Planning Services

Family planning services are available to help prevent unintended or unplanned pregnancies. Family planning services include examinations, assessments, and traditional contraceptive devices. The Contractor should agree to make available all family planning services to Medicaid MHN program members as specified in **MHN Policy and Procedure Guide.** Medicaid MHN program members shall have the freedom to receive family planning services outside the Contractor's provider network by appropriate Medicaid providers without any restrictions. Medicaid MHN program members should be encouraged by the Contractor to receive family planning services through the Contractor's network of providers to ensure continuity and coordination of a member's total care.

#### 4.6.2 Communicable Disease Services

Communicable disease services are available to help control and prevent diseases such as tuberculosis (TB), sexually transmitted diseases (STD), and Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) infection. The Contractor shall make available communicable disease services to Medicaid MHN program members as specified in **MHN Policy and Procedure Guide**. Medicaid MHN Program Members shall have the freedom to receive TB, STD, and HIV/AIDS services outside the Contractor's provider network by the state public health agency without any restrictions.

4.6.2.1 Prompt Reporting of South Carolina Reportable Diseases, and Access to Clinical Records of Patients with Reportable Diseases

The Contractor or its network providers shall comply with S.C. Code Ann. Sections 44-1-80 through 44-1-140 and Sections 44-29-10 through 44-29-90 by reporting all cases of TB, STD and HIV/AIDS infection to the state public health agency within 24 (twenty-four) hours of notification by provider or from date of service. Refer to the annual issue of "Epi-Notes", the Department of Health and Environmental Control's (DHEC) Disease Prevention and Epidemiology Newsletter for the list of reportable conditions by physicians and health care institutions required under State law and listed in **MHN Policy and Procedure Guide**.

4.6.2.2 Control and Prevention of Communicable Diseases

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DHEC is the state public health agency responsible for promoting and protecting the public's health and has the primary responsibility for the control and prevention of communicable diseases such as TB, STD, HIV/AIDS infection and vaccine preventable diseases. DHEC provides a range of primary and secondary prevention services through its local health clinics to provide and/or coordinate communicable disease control services.

The Contractor and/or its network provider for clinical management, treatment and directly observed therapy must refer TB suspects and cases to DHEC. This care will be coordinated with the Contractor's PCP.

# 4.6.2.3 Patient Confidentiality

The public state health agency will promote coordination of care while ensuring patient confidentiality. Notwithstanding §4.6.2 of this Contract, in compliance with S.C. Code Ann. §44-29-135 (Supp. 2000, as amended), for Medicaid MHN Program members who choose diagnosis and treatment for TB, STD and HIV/AIDS infection in the state public health clinics, information regarding their diagnosis and treatment will be provided to the Contractor's primary care provider assigned to that member only with the written consent of the member, unless otherwise provided by law.

# 4.7 <u>Manner of Service Delivery and Provision</u>

In establishing and maintaining the service delivery network, the Contractor must consider the following:

- The anticipated Medicaid enrollment.
- The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented by the Contractor
- The number of network providers who are not accepting new Medicaid patients
- The geographic location of providers and Medicaid members; considering distance travel time, means of transportation ordinarily used by Medicaid members, and whether the location provides physical access for Medicaid members with disabilities.

The Contractor shall provide female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the members designated source of primary care if that source is not a women's health specialist. The Contractor shall provide a second opinion from a qualified health care professional.

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#### 4.7.1 Service Area

The Contractor is authorized to develop MHNs in all counties.

### 4.7.2 Contractor's Network Composition

The Contractor shall not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. The Contractor shall not discriminate for the participation, reimbursement, or indemnification of any provider who serves high-risk populations or specializes in conditions that require costly treatment. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for it decision.

# 4.7.3 Primary Care Providers (PCP)

A PCP in the Medicaid MHN Program must be a physician or network provider/subcontractor who provides or arranges for the delivery of medical services, including case management, to assure that all services that are found to be medically necessary are made available in a timely manner as outlined in § 4 of this Contract. The following practice specialties are considered Primary Care Providers: Family Medicine, General Practice, Pediatrics, Internal Medicine, OB/GYN, Federally Qualified Health Centers (FQHC), and Rural Health Clinics (RHC). The PCP may practice in a solo or group setting or may practice in a clinic (i.e., Federally Qualified Health Center or Rural Health Center) or outpatient clinic. The Contractor shall agree to provide at least one (1) full time equivalent (FTE) PCP per two thousand five hundred (2,500) members (Medicaid MHN Program members and existing commercial members).

The Medicaid MHN program member has the freedom to request a change of primary care provider within the time frames and guidelines established by the Contractor. The time frames and guidelines established by the Contractor must not conflict with the Federal rules and regulations governing time frames.

The Contractor shall identify to SCDHHS or its designee monthly any PCP approved to provide services under this Contract who will not accept new patients.

The PCP shall serve as the member's initial and most important point of interaction with Contractor's provider network. The PCP responsibilities shall include, at a minimum:

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- 4.7.3.1 Managing the medical and health care needs of members to assure that all medically necessary services are made available in a timely manner;
- 4.7.3.2 Monitoring and follow-up on care provided by other medical service providers for diagnosis and treatment, to include services available under Medicaid fee-for-service;
- 4.7.3.3 Providing the coordination necessary for the referral of patients to specialists and for the referral of patients to services that may be available through fee-for-service Medicaid.
- 4.7.3.1 Maintaining a medical record of all services rendered by the PCP and other referral providers.

### 4.8 Service Accessibility Standards

The Contractor and its network providers/subcontractors shall provide or arrange for Primary Care coverage services, consultation or referral, and treatment of emergency medical conditions, twenty-four hours per day, seven days per week as defined in the MHN Policy and Procedure Guide. Automatic referral to the hospital emergency department for services does not satisfy this requirement. Members must be allowed to obtain emergency services outside the Network regardless of whether the PCP referred the member to the provider that furnished the services. The Rights of Members, as detailed in the MHN Policy and Procedure Guide, shall always be taken into account when rendering treatment.

The Contractor and its network providers/subcontractors shall ensure access to health care services (distance traveled, waiting time, length of time to obtain an appointment, after-hour care) in accordance with the prevailing medical community standards in the provision of services under this Contract. The SCDHHS will monitor the Contractor's service accessibility. The Contractor shall provide available, accessible and adequate numbers of service locations, service sites, professional, allied and para-medical personnel for the provision of primary care services on a 24-hour-a-day, 7-days-a week basis, as described in **the Medical Homes Network Standards** and the **MHN Policy and Procedure Guide**, and shall take corrective action if there is failure to comply by any provider. At a minimum, this shall include:

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# 4.8.1 Twenty-Four (24) Hour Coverage

The Contractor shall ensure that all medically necessary primary medical care is available on a twenty-four (24) hours a day, seven (7) days a week basis through its network providers, and shall maintain, twenty-four (24) hours per day, seven (7) days per week telephone coverage to instruct Medicaid MHN Program members on where to receive emergency and urgent health care.

The Contractor's network provider/subcontractor may elect to provide 24 hour coverage by direct access or through arrangement with a triage system. The triage system arrangement must be prior approved by SCDHHS.

# 4.8.2 Scheduling/Appointment Waiting Times

The Contractor shall ensure that its subcontractors/network providers have an appointment system for primary care medical services which are in accordance with prevailing medical community standards but shall not exceed the following requirements:

4.8.2.1	Routine well visits scheduled within 45 days of presentation or notification, 15 days if member is
AT A	pregnant;
4.8.2.2	Routine sick visits scheduled within three (3) days of
15 12	presentation or notification;
4.8.2.3	Urgent, non-emergency visits within forty-eight (48)
	hours; and
4.8.2.4	Emergent or emergency visits immediately upon
	presentation at a service delivery site;
4.8.2.5	Waiting times should not exceed forty-five (45)
	minutes for scheduled appointment of a routine
	nature.
\V/\\	

Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures.

Walk-in patients with urgent needs should be seen within forty-eight (48) hours.

The Contractor's network providers/subcontractors shall not use discriminatory practices with regard to members such as separate waiting rooms, separate appointment days, or preference to private pay patients.

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# 4.9 <u>Authorization and Referral System</u>

The Contractor shall have a referral system for Medicaid MHN Program members requiring specialty health care services. For certain programs, prior authorization is not required. These programs are detailed in the **MHN Policy and Procedure Guide.** The Contractor shall provide monitoring and follow-up on care provided by other medical service providers for diagnosis and treatment, to include externally referred services.

There must be written evidence of the communication of the patient results/information to the referring physician by the specialty health care provider or continued communication of patient information with the primary care provider.

### 4.10 Cultural Considerations

The Contractor shall promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

When the Contractor identifies Medicaid members who have visual and/or hearing impairments, an interpreter must be made available for the South Carolina Medicaid MHN Program member(s).

### 5 **SUBCONTRACTS**

The Contractor shall provide or assure the provision of all covered services specified in §4 of this Contract. The Contractor may provide these services directly or may enter into subcontracts with providers who will provide services to the members in exchange for payment by the Contractor for services rendered. Subcontracts are required with all providers of services unless otherwise approved by SCDHHS. The Contractor shall remain responsible for all contractual requirements including those performed by the subcontractor(s). Any plan to delegate responsibilities of the Contractor to a subcontractor shall be approved by SCDHHS.

Model subcontracts, including provider per member per month care coordination fee rates, shall be submitted in advance to SCDHHS and shall include a copy of and specify that the subcontractor adhere to the Quality Assessment and Performance Improvement Program (QAPI) Requirements specified by SCDHHS contained in **MHN Policy and Procedure Guide**, Quality Assessment and Case Management (CM) Requirements. The Contractor shall submit to SCDHHS for review and approval, prior to execution, any subcontract, including provider rates, that is materially different from the model subcontract for that provider type. The SCDHHS shall have the right to review and approve any and all subcontracts entered into for the provision of any services under this contract.

Notification of amendments or changes to any subcontract which, in accordance with §2.7 of this Contract, materially affects this Contract shall be provided to

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SCDHHS prior to the execution of the amendment in accordance with §1.7 of this Contract. The Contractor shall not execute subcontracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to §§ 1128 (42 U.S.C. 1320a-7) (2001, as amended) or 1156 (42 U.S.C. 1320 c-5) (2001, as amended) of the Social Security Act or who are otherwise barred from participation in the Medicaid and/or Medicare program. The Contractor shall not enter into any relationship (See § 1.3 – Definitions) with anyone debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from nonprocurement activities under regulations issued under Executive Orders. In the event of non-renewal of a subcontractor's agreement, the Contractor shall inform SCDHHS of the intent to terminate the subcontract ninety (90) calendar days prior to the effective date of termination of said subcontract. If the Contractor terminates the subcontract for cause, the Contractor shall notify SCDHHS sixty (60) calendar days prior to the termination. If the subcontract is terminated for any material breach, the Contractor shall give the subcontractor thirty (30) calendar days written notice and shall notify SCDHHS of the termination sixty (60) calendar days prior to the termination of said subcontract. The Contractor must make a good faith effort to give written notice of termination of a contracted provider, within fifteen (15) days after receipt of issuance of the termination notice, to each enrollee who received his or her primary care from or was seen on a regular basis by the terminated provider.

# 5.1 <u>Subcontract Requirements</u>

All subcontracts executed by the Contractor pursuant to this section shall, at a minimum, include the requirements listed below. No other terms or conditions agreed to by the Contractor and subcontractor shall negate or supersede the following requirements.

- 5.1.1 Be in writing and signed by the Contractor and subcontractor;
- 5.1.2 Specify the effective dates of the subcontractor agreement;
- 5.1.3 Specify in the subcontractor agreement that the subcontractor agreement and its appendices contain all the terms and conditions agreed upon by the parties. Require that no modification or change of any provision of the subcontract shall be made unless such modification is incorporated and attached as a written amendment to the subcontract and signed by the parties;
- 5.1.4 Assure that the subcontractor shall not enter into any subsequent agreements or subcontracts for any of the work contemplated under the subcontractor agreement without approval of the Contractor;
- 5.1.5 Specify that the services covered by the subcontractor agreement must be in accordance with the Title XIX SC State Medicaid Plan and require that the subcontractor shall provide these services to members through the last day that the subcontract is in effect, all

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- final Medicaid benefit determinations are within the sole and exclusive authority of SCDHHS or its designee;
- 5.1.6 Specify that the subcontractor may not refuse to provide medically necessary or covered preventive services to Medicaid MHN program members covered under this Contract for non-medical reasons;
- 5.1.7 Require that the subcontractor be currently licensed and/or certified under applicable state and federal statutes and regulations and shall maintain throughout the term of the subcontract all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated by the Contractor;
- 5.1.8 Specify the amount, duration and scope of services to be provided by the subcontractor;
- 5.1.9 Provide that emergency services be rendered without the requirement of prior authorization of any kind;
- 5.1.10 If the subcontractor performs laboratory services, the subcontractor must meet all applicable state and federal requirements;
- 5.1.11 Require that an adequate record system be maintained for recording services, service providers, charges, dates and all other commonly accepted information elements for services rendered to members pursuant to the agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under this Contract). Medicaid MHN program members and their representatives shall be given access to and requested copies of the members medical records, to the extent and in the manner provided by S.C. Code Ann. §44-115-10 et. seq., (Supp. 2000) as amended and subject to reasonable charges;
- 5.1.12 Require that any and all member records—financial, medical, etc.—be retained for a period of three (3) years after the last payment was made for services provided to a member and retained further if the records are under review or audit until the review or audit is complete. This requirement pertains to the retention of records for Medicaid purposes only; other state or federal rules may require longer retention periods. Current State law (SC ST SEC 44-115-120) requires physicians to retain their records for at least ten (10) years for adult patients and at least thirteen (13) years for minors. These minimum record keeping periods begin to run from the last date of treatment. After these minimum record-keeping periods, state law allows for the destruction of records. Said records shall be made available for fiscal audit, medical audit, medical review, utilization review, and

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- other periodic monitoring upon request of authorized representative of SCDHHS.
- 5.1.13 Provide that SCDHHS, U.S. Department of Health and Human Services (HHS), CMS, Office of Inspector General Comptroller, State Auditor's Office, and the South Carolina Attorney General's Office shall have the right to evaluate through inspection, or other means, whether announced or unannounced, any records pertinent to this Contract including quality, appropriateness and timeliness of services and such evaluation, and when performed, shall be performed with the cooperation of the Contractor. Upon request, the Contractor shall assist in such reviews;
- 5.1.14 Whether announced or unannounced, provide for the participation and cooperation in any internal and external quality assessment review, case management and grievance procedures established by the Contractor and/or SCDHHS or its designee;
- 5.1.15 Specify that the subcontractor shall monitor the quality of services delivered under the agreement and initiate plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the Contractor/subcontractor practices and/or the standards established by SCDHHS or its designee;
- 5.1.16 Require that the subcontractor comply with plan of correction initiated by the Contractor and/or required by SCDHHS;
- 5.1.17 Provide for submission of all reports and clinical information required by the Contractor, including EPSDT (if applicable);
- 5.1.18 Require safeguarding of information about Medicaid MHN program members according to applicable state and federal laws and regulations and as described in §13.22 and §13.29 and of this Contract;
- 5.1.19 Provide the name and address of the official payee to whom payment shall be made;
- 5.1.20 Make full disclosure of the method and amount of compensation or other consideration to be received from the Contractor;
- 5.1.21 Provide for prompt submission of information needed to make payment;
- 5.1.22 Specify that the subcontractor shall accept payment made by the Contractor as payment-in-full for covered services provided and shall not solicit or accept any surety or guarantee of payment from the member. Member shall include the patient, parent(s), guardian,

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- spouse or any other legally responsible person of the member being served;
- 5.1.23 Specify that at all times during the term of the agreement, the subcontractor shall indemnify and hold SCDHHS harmless from all claims, losses, or suits relating to activities undertaken pursuant to the Contract between SCDHHS and the Contractor, unless the subcontractor is a state agency. For subcontractors that are not state agencies, the indemnification may be accomplished by incorporating §13.26 of this Contract in its entirety in the subcontractor's agreement or by use of other language developed by the Contractor and approved by SCDHHS. For state agencies, the liability protection may be accomplished by incorporating language developed by the state agency and approved by SCDHHS.
- 5.1.24 Require the subcontractor to secure all necessary liability and malpractice insurance coverage as is necessary to adequately protect the plan's members and the Contractor under the agreement. The subcontractor shall provide such insurance coverage at all times during the agreement and upon execution of the subcontract agreement furnish the Contractor with written verification of the existence of such coverage;
- 5.1.25 Specify that the subcontractor agrees to recognize and abide by all state and federal laws, regulations and guidelines applicable to the provision of services under the Medicaid MHN Program;
- 5.1.26 Provide that the agreement incorporates by reference all applicable federal and state laws or regulations, and revisions of such laws or regulations shall automatically be incorporated into the agreement as they become effective. In the event that changes in the agreement as a result of revisions and applicable federal or state law materially affect the position of either party, the Contractor and subcontractor agree to negotiate such further amendments as may be necessary to correct any inequities;
- 5.1.27 Specify procedures and criteria for any alterations, variations, modifications, waivers, extension of the agreement termination date, or early termination of the agreement and that such change shall only be valid when reduced to writing, duly signed and attached to the original of the agreement;
- 5.1.28 Specify that the Contractor and subcontractor recognize that in the event of termination of this Contract between the Contractor and SCDHHS for any of the reasons described in this Contract, the Contractor shall immediately make available, to SCDHHS, or its designated representative, in a usable form, any and all records, whether medical or financial, related to the Contractor's and subcontractor's activities undertaken pursuant to the

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- Contractor/subcontractor agreement. The provision of such records shall be at no expense to SCDHHS;
- 5.1.29 That the Contractor and subcontractor shall be responsible for resolving any disputes that may arise between the two (2) parties, and that no dispute shall disrupt or interfere with the provisions of services to the Medicaid MHN program member;
- 5.1.30 Include a conflict of interest clause as stated in **§13.33** of this Contract between the Contractor and SCDHHS;
- 5.1.31 Specify that the subcontractor must adhere to the Quality Assessment Performance Improvement (QAPI) and Case Management (CM) requirements as outlined in **MHN Policy and Procedure Guide**. The QAPI and CM requirements shall be included as part of the subcontract between the Contractor and the subcontractor:
- 5.1.32 All subcontractors shall give the Contractor immediate notification in writing by certified mail of any administrative legal action or complaint filed and prompt notice of any claim made against subcontractor by a subcontractor, or member which may result in litigation related in any way to this Contract with SCDHHS. The Contractor shall assure that all responsibilities related to the subcontract are performed in accordance with the terms of this Contract:
- 5.1.33 Contain no provision which provides incentives, monetary or otherwise, for the withholding of medically necessary care. See MHN Policy and Procedure Guide, Incentive Plans;
- 5.1.34 Specify that the subcontractor shall not assign any of its duties and/or responsibilities under this Contract without the prior written consent of the Contractor;
- 5.1.35 Specify that Contractor shall not prohibit or otherwise restrict a network provider/subcontractor from advising a member about the health status of the member or medical care or treatment for the member's condition or disease, regardless of whether benefits for such care or treatment are provided under the contract, if the network provider/subcontractor is acting within the lawful scope of practice.
- 5.1.36 In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.) (2001, as amended) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended), the Provider must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this agreement.

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- 5.1.37 Contain no provision which restricts a network provider/subcontractor from contracting with another managed care entity.
- 5.1.38 In the event the Contractor discontinues operations, any network provider who terminates its contract with the Contractor as a result of this discontinuation shall receive their share of any cost savings agreed upon with the Contractor.

### 6 EDUCATION, SELECTION AND ENROLLMENT PROCESS

The South Carolina Department of Health and Human Services (SCDHHS) determines eligibility for Medicaid for all coverage groups except for Supplemental Security Income (SSI). The Social Security Administration (SSA) determines eligibility for SSI. Once SCDHHS or SSA determines an applicant eligible for Medicaid, the pertinent eligibility information is entered in the Medicaid Eligibility Determination System (MEDS). The rights afforded to potential MHN members are detailed in MHN Policy and Procedure Guide, Members' Bill of Rights.

# 6.1 Enrolling Eligibles in the Contractor's Plan

If an eligible is enrolled in a managed care program, the SCDHHS or its designee will enter the enrollment information as provided in §6.2 of this Contract. SCDHHS or its designee will provide the Contractor notification of the Medicaid eligibles who are enrolled, re-enrolled, or disenrolled from their managed care plan as specified in §6.7. The Contractor shall contact the members as required in §8 of this Contract. SCDHHS or its designee will notify the eligibles of their enrollment and of their rights to change providers or to disenroll from the plan for cause.

The Contractor shall not discriminate against Medicaid MHN program members on the basis of their health history, health status or need for health care services or adverse change in health status and shall accept eligibles in the order in which they apply. This applies to enrollment, reenrollment or disenrollment from the Contractor's plan. The Contractor shall provide services to all eligible Medicaid MHN program members who enroll in the Contractor's plan.

### 6.2 Enrollment Period

The Medicaid MHN program members shall be enrolled for a period of twelve (12) months contingent upon their continued Medicaid eligibility. The member may request disenrollment without cause at any time during the 90 days following the date of the member's initial enrollment with the MHN. A member shall remain in the Contractor's plan unless the member submits a written or oral request to disenroll, to change managed care plans for cause or unless the member becomes ineligible for Medicaid and/or MHN enrollment. Oral requests to disenroll shall be confirmed in writing. If a member's request to disenroll is not acted on within sixty (60)

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days, it shall be considered approved. The following are considered cause for disenrollment by the member:

- The member moves out of the MHN's service area;
- The plan does not, because of moral or religious objections, cover the service the member seeks;
- The member needs related services (for example, a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the member's PCP or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk; and
- Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's health care needs.

Annually, SCDHHS or its designee will mail a re-enrollment offer to Medicaid MHN members to determine if they wish to continue to be enrolled with the Contractor's plan no less than 60 days prior to the start of the re-enrollment period. The re-enrollment notice shall inform the MHN members of their disenrollment rights. Unless the member becomes ineligible for the Medicaid MHN Program or provides written notification that they no longer wish to be enrolled in the Contractor's plan, the member will remain enrolled with the Contractor.

A Medicaid MHN program member who becomes disenrolled due to loss of Medicaid eligibility and submits a new enrollment form and becomes enrolled in the Contractor's plan within sixty (60) calendar days from the effective date of disenrollment may re-enroll with the Contractor's plan without going through the education process again. See §6.6 for additional information on re-enrollment.

## 6.3 <u>Effective Date of Enrollment</u>

For a period of time during the effective dates of this contract, SCDHHS will operate its enrollment system under one of the following procedures. If the enrollment broker is operating in a county, the Contractor may not enroll members. This process will be conducted by SCDHHS and the enrollment broker. If the enrollment broker is not operating in a county, the Contractor can enroll members and send that information to SCDHHS for review and processing. The SCDHHS or its designee will enter all enrollment information and updates within three (3) working days of receipt of a processable enrollment form/spreadsheet. A processable enrollment form/spreadsheet is one that does not need to be returned to the recipient for further information and one that passes front end edits when keyed. (Examples of front-end edits include, but are not limited to:

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Recipient Medicaid number must be valid and recipient must be eligible for Medicaid.)

#### 6.4 Member Initiated Disenrollment and Change of Managed Care Plans

The Contractor may conduct an initial follow up for all voluntary disenrollees. These members will be identified on the member listing file with a special indicator. The Contractor may contact the member upon receipt of the monthly member listing file. However, follow up must be within the guidelines outlined in **MHN Policy and Procedure Guide**, Marketing, Member Education and Enrollment. The enrollment process specific to that county shall apply. The effective date of enrollment will be as specified in section **6.3** of the contract.

## 6.5 Contractor Initiated Member Disenrollment of Participation

The Contractor may request to disenroll a Medicaid MHN program member based upon the following reasons:

- Contractor ceases participation in the Medicaid MHN program or in the Medicaid MHN program member's service area;
- Medicaid MHN program member dies;
- Becomes an inmate of a Public Institution;
- Moves out of State:
- Becomes institutionalized in a Long Term Care Facility/Nursing Home for more than thirty (30) days;
- Enters the Medically Fragile Children's Program; or
- Fails to follow the rules of the managed care plan.

The Contractor's request for member disenrollment must be made in writing to SCDHHS using the SCDHHS Form 280-2 (10/06) in the MHN Policy and Procedure Guide and the request must state the detailed reason for disenrollment. SCDHHS will determine if the Contractor has shown good cause to disenroll the member and SCDHHS will give written notification to the Contractor and the member of its decision. The Contractor and the member shall have the right to appeal any adverse decision.

The Contractor shall not terminate a member's enrollment because of any adverse change in the member's health except when the member's continued enrollment in the Plan seriously impairs the Contractor's ability to furnish services to either this particular member or other members.

If the Contractor ceases participation in the eligible's service area or ceases participation in the Medicaid MHN program, the Contractor shall notify SCDHHS in accordance with the termination procedures in §13.2.8 of this Contract. SCDHHS or its designee will notify MHN program members and offer them the choice of regular fee for service Medicaid or another managed care plan in their service area. If there are no other managed care options, they will remain on regular Medicaid. The Contractor shall assist the SCDHHS in transitioning Medicaid MHN

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program members to another managed care plan or to the Medicaid feefor-service delivery system to ensure access to needed health care services.

#### 6.6 SCDHHS Initiated Member Disenrollment

The SCDHHS will notify the Contractor of the member's disenrollment due to the following reasons:

- Loss of Medicaid eligibility or loss of Medicaid MHN program eligibility; Death of a Member
- Intentional Submission of Fraudulent Information:
- Becomes an inmate of a Public Institution;
- Moves out of State;
- Becomes institutionalized in a Long Term Care Facility/Nursing Home for more than thirty (30) days;
- Enters the Medically Fragile Children's Program;
- Loss of Contractor's Participation; or
- Enrollment in another Medicaid managed care plan

The Contractor shall immediately notify SCDHHS when it obtains knowledge of any Medicaid MHN program member whose enrollment should be terminated prior to SCDHHS' knowledge. See MHN Policy and Procedure Guide.

The Contractor shall have the right to contact MHN members who have been disenrolled when the reason for disenrollment is "ineligible for Medicaid". This means that Medicaid eligibility has been terminated. These members will be identified on the member listing file with a special indicator. The Contractor may contact the member upon receipt of the monthly member listing file to assist the member in taking any possible actions to continue or regain eligibility. If the member regains Medicaid eligibility, within 60 days of the disenrollment date, the member will be automatically re-enrolled with the Contractor. If eligibility is regained after 60 days of the disenrollment date, the member will need to contact SCDHHS to initiate re-enrollment.

Automatic re-enrollment will only occur in cases where the Medicaid MHN Program Member has not submitted a written request to disenroll from the Contractor's plan.

In an effort to minimize the number of disenrollments due to loss of Medicaid eligibility, DHHS or its designee will provide the Contractor with a monthly listing of Medicaid MHN program members who were mailed an Eligibility Redetermination/Review Form during the month. The Contractor may use this information to assist its members in taking appropriate action to maintain Medicaid eligibility.

#### 6.7 Notification of Membership to Managed Care Plan

C 0 contract no MC Page 34 of 69 pages SCDHHS or its designee will notify each Contractor at specified times each month of the Medicaid eligibles who are enrolled, re-enrolled, or disenrolled from their managed care plan for the following month. The Contractor will receive this notification through electronic media. See **MHN Policy and Procedure Guide** for record layout.

SCDHHS or its designee will use its best efforts to ensure that the Contractor receives timely and accurate enrollment and disenrollment information. In the event of discrepancies or unresolvable differences between the SCDHHS and the Contractor, regarding enrollment, disenrollment and/or termination, SCDHHS will be responsible for taking the appropriate action for resolution.

## 6.8 Toll Free Telephone Number

SCDHHS or its designee will maintain a toll free telephone number for Medicaid applicants and eligibles to call and ask questions or obtain information about the enrollment process, including but not limited to, managed care plans available to them.

## 6.9 <u>Tracking Slot Availability</u>

The Contractor shall identify the maximum number of Medicaid MHN Program members it is able to enroll and maintain under this Contract. The Contractor shall accept Medicaid eligibles as Medicaid MHN program members in the order in which they apply as determined by SCDHHS up to the limits specified in **MHN Policy and Procedure Guide.** The Contractor agrees to provide services to Medicaid MHN program members up to the maximum enrollment limits indicated by the Contractor in **MHN Policy and Procedure Guide.** 

#### 6.10 Medicaid Cards

Each MHN member should have a plastic South Carolina Partners for Health Medicaid card. This new card allows the provider to verify eligibility utilizing the automated IVRS System at 1-888-809-3040, the Web Tool, or software installed in his/her office. As a part of the eligibility verification, the provider is informed of client enrollment in a Medicaid MHN.

#### 6.11 Billing and Reconciliation

If the Contractor desires a reconciliation of the enrollment, re-enrollment, and disenrollment data received from SCDHHS, the Contractor shall be responsible for that reconciliation. In the event of discrepancies, the Contractor shall notify SCDHHS or its designee immediately of the discrepancy.

#### 7 MARKETING

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Marketing is defined as any activity conducted on behalf of the Contractor that explicitly or implicitly refers to the Contractor's Medicaid participation, S.C. Medicaid MHN Program or Title XIX, and is targeted in anyway toward Medicaid eligibles for the sole purpose of providing information regarding the contractor's plan. Activities involving distribution and completion of the MHN enrollment form during the course of marketing activities is an enrollment function and is considered separate and distinct from marketing.

Under the S.C. Medicaid MHN Program, SCDHHS or its designee will perform all direct marketing to eligibles or potential eligibles. The Contractor shall not market directly to Medicaid applicants/recipients (including direct mail advertising, door-to-door, telephonic, or other "cold call" marketing). The Contractor shall not implement any marketing activities relative to this Contract without making full disclosure to and obtaining prior written approval from SCDHHS or its designee for each event.

SCDHHS may impose sanctions against the Contractor if SCDHHS determines that the Contractor distributed directly/indirectly or through any agent or independent contractor marketing materials and/or MHN enrollment forms in violation of federal law.

## 7.1 Information Provided for Enrollment Process

The Contractor shall provide each member with clear, accurate and truthful information about the Contractor's health plan to ensure compliance with this Contract and with state and federal laws and regulations. The Contractor shall be responsible for developing and distributing its own member specific marketing, educational and enrollment materials including but not limited to, evidence of coverage and other materials designed for member education. All written material shall be written at a grade level no higher than the fourth (4th) grade, or as determined appropriate by SCDHHS. The Contractor shall not cause or knowingly permit the use of advertising which is untrue, misleading or deceptive. The information must include a statement that enrollment in the Contractor's Plan by a Medicaid applicant/eligible shall be voluntary.

The Contractor shall inform the members that enrollment shall be for a period of twelve (12) months contingent upon their continued Medicaid eligibility and that the member may request disenrollment without cause at any time during the 90 days following the date of the member's initial enrollment with the MHN.

#### 7.2 <u>Marketing Plan and Materials</u>

The Contractor shall develop and implement a marketing plan for participation in the SC Medicaid MHN Program. The Contractor shall describe the marketing activities it will undertake during the Contract period. The Contractor's marketing plan shall take into consideration the projected enrollment levels. The Contractor shall obtain prior approval from SCDHHS for each community event designed to increase community awareness of their participation in the Medicaid MHN Program. At such

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events, the Contractor may be allowed to present enrollment materials and perform direct enrollment activities. Enrollment activities by the contractor are specifically prohibited in counties where the enrollment broker is performing that function. Only written materials describing the Contractor's plan, as approved by SCDHHS, can be distributed at such events. All marketing activities shall comply with **MHN Policy and Procedure Guide**, Marketing and this Contract.

Materials used for the purpose of marketing to Medicaid MHN program members must be prior approved by SCDHHS and meet the standards for marketing materials outlined in **MHN Policy and Procedure Guide**. The Contractor shall ensure that where ten percent (10%) of the resident population of a county is non-English speaking and speaks a specific foreign language, materials shall be made available in that specific language to assure a reasonable chance for all potential members to make an informed choice of managed care plans. The Contractor is required to provide all materials designed for beneficiaries in Spanish. The Contractor is prohibited from offering or giving any form of compensation or reward as an inducement to enroll in the Contractor's plan.

## 7.3 Approval of Marketing Plan and Materials

The Contractor shall submit to SCDHHS or its designee all marketing plans and written materials directed at Medicaid eligibles or potential eligibles for approval. These materials include, but are not limited to, materials produced for marketing, member education, evidence of coverage, and grievance procedures. Marketing materials include all types of media including brochures, leaflets, newspapers, magazines, radio, television, billboard and yellow page advertisements directed at Medicaid eligibles or potential eligibles. They also include internet-based materials.

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#### 8 POST ENROLLMENT PROCESS

The post enrollment process for the Medicaid MHN program shall be as follows:

#### 8.1 Member Services Availability

The Contractor shall maintain an organized, integrated member/patient services function, to be operated during regular business hours, within the plan to assist members in selection of a primary care provider, provide explanation of the Contractor's policies and procedures, (re: access and availability of health services) provide additional information about the primary care providers and/or specialist(s), facilitate referrals to specialists, and assist in the resolution of service and/or medical delivery problems and member complaints.

The Contractor shall agree to maintain a toll-free telephone number for Medicaid MHN program members' inquiries. The toll-free telephone number shall be required to provide prior authorization/access and information of services during evenings and weekends.

#### 8.2 Member Education

The Contractor shall educate members regarding the appropriate utilization of services access to specialized care, emergency care and the process for prior authorization of services. Such education shall be provided no later than fourteen (14) calendar days from receipt of enrollment data from SCDHHS or its designee, and as needed thereafter. The Contractor shall identify and educate members who access the system inappropriately and provide continuing education as needed.

The Contractor shall ensure that where at least ten percent (10%) or more of the resident population of a county is non-English speaking and speaks a specific foreign language, then materials must be made available in that specific language to assure a reasonable chance for all members to understand how to access the plan and use services appropriately. The Contractor is required to provide all materials designed for beneficiaries in Spanish.

The Contractor shall have written policies and procedures for educating Medicaid MHN program members about their benefits.

The Contractor shall coordinate with SCDHHS or its designee member education activities as outlined in **MHN Policy and Procedure Guide** to meet the health care educational needs of the Medicaid MHN program members.

The Contractor shall not discriminate against Medicaid MHN members on the basis of their health history, health status or need for health care

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services. This applies to enrollment, re-enrollment or disenrollment from the Contractor's plan.

#### 8.2.1 Enrollment Materials

The Contractor's written enrollment materials shall be governed by the requirements and limitations described in **MHN Policy and Procedure Guide**. The enrollment materials must be approved by SCDHHS or its designee prior to distribution or use by the Contractor. All materials shall be written at a grade level no higher than fourth grade, "or as determined appropriate by SCDHHS", and contain the minimum information as outlined in the **MHN Policy and Procedure Guide**.

The Contractor shall include the names, locations, telephone numbers of and non-English languages spoken by current contracted providers in the enrollee's service area, including the identification of providers that are not accepting new patients. The Contractor shall make clear any restrictions on the enrollee's freedom of choice among network providers.

### 8.2.2 Member Handbook

SCDHHS shall provide the Contractor with an electronic version of the MHN Member Handbook in both English and Spanish. The Contractor shall provide each member with a member handbook and other written materials information.

## 8.3 Member's Rights and Responsibilities

The Contractor shall furnish Medicaid MHN program members with both verbal and written information about the nature and extent of their rights and responsibilities as a member of the Contractor's plan. The rights afforded to current members are detailed in MHN Policy and Procedure **Guide, Members'** Bill of Rights. The written information shall be written at a reading comprehension level no higher than fourth (4th) grade, "or as determined appropriate by SCDHHS." The minimum information shall include: the member's rights to receive written information about the Contractor's managed care plan including information on the structure and operation of the Plan; the network providers/subcontractors providing the member's health care, including information on any providers who are non-English speaking; information about the amount, duration, and scope of benefits available and how to obtain these benefits; confidentially of patient information; the right to file grievances or complaints about the Contractor and/or care provided; any restrictions on the member's freedom of choice among network providers; the extent to which, and how, after-hours and emergency coverage are provided; and any other information that affects the member's enrollment into the Contractor's plan. The Contractor shall notify the Medicaid MHN program members at least annually following initial enrollment of their right to request and receive this information.

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The Medicaid MHN program members' responsibilities shall include but are not limited to: informing the Contractor of the loss or theft of their ID card; presenting their ID card when using health care services; to be familiar with the plan's procedures to the best of the member's abilities; and/or to call or contact the Contractor to obtain information and have questions clarified; to provide participating network providers with accurate and complete medical information; follow the prescribed treatment of care recommended by the provider or let the provider know the reasons the treatment cannot be followed, as soon as possible; and make every effort to keep any agreed upon appointments, and follow-up appointments and to access preventive care services.

## 9 GRIEVANCE AND APPEAL PROCEDURES

The Contractor shall establish and maintain a procedure for the receipt and prompt internal resolution of all grievances and appeals in accordance with S.C. Code Ann. §38-33-110 (Supp. 2002) as amended and 42 C.F.R. Section 438.400, et seq. The Contractor's grievance and appeals procedures and any changes thereto must be approved in writing by SCDHHS prior to their implementation and must include at a minimum the requirements set forth herein. The Contractor shall refer all Medicaid MHN program members who are dissatisfied with the Contractor or its subcontractor in any respect to the Contractor's designee authorized to require corrective action. In all cases, where the member has a grievance about treatment by the Contractor, or its subcontractor, the member must exhaust the Contractor's internal grievance/appeal procedures prior to accessing the State's Fair Hearing process.

If the member is grieving a disenrollment issue, the Contractor's grievance process must be completed in time to permit the disenrollment, if approved, to be effective in accordance with the timeframe specified in 42CFR 438.56(e)(1). If as a result of the grievance process the Contractor approves the disenrollment, the State shall not be required to make a determination.

## 9.1 Notice of Grievance and Appeal Procedures

The Contractor shall ensure that all Medicaid MHN program members are informed of the State's Fair Hearing process and of the Contractor's grievance and appeal procedures. The Contractor shall provide to each member a member handbook that shall include descriptions of the Contractor's grievance and appeal procedures. Forms on which members may file grievances, appeals, concerns or recommendations to the Contractor shall be available through the Contractor, and must be provided upon request of the member.

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## 9.2 <u>Grievance/Appeal Records and Reports</u>

A copy of an oral grievances log and records of disposition of written appeals shall be retained for three (3) years and in accordance with the provisions of the S.C. Code Ann. § 38-33-110 (2)(a) (Supp. 2002) as amended. If any litigation, claim negotiation, audit, or other action involving the documents or records has been started before the expiration of the three (3) year period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular five-year period, whichever is later.

The Contractor shall provide to SCDHHS on a quarterly basis a written report of the grievances/appeals, to include: member's name and Medicaid number, summary of grievances and appeals; date of filing; current status; resolutions and resulting corrective action. The Contractor will be responsible for promptly forwarding any adverse decisions to SCDHHS for further review/action upon request by SCDHHS or the Medicaid MHN Program member. The SCDHHS may submit recommendations to the Contractor regarding the merits or suggested resolution of any grievance or appeal. See MHN Policy and Procedure Guide.

## 9.3 Requirements for State Fair Hearings.

- 9.3.1 <u>Availability</u>. If the member has exhausted the Contractor level appeal procedures, the member may request a State Fair Hearing within thirty (30) days from the date of the Contractor's notice of resolution.
- 9.3.2 <u>Parties</u>. The parties to the State Fair Hearing include the Contractor as well as the member and his or her representative or the representative of a deceased member's estate.

## 9.4 <u>Information About the Grievance System to Providers and Subcontractors</u>

The Contractor must provide the information specified at 42 C.F.R. Section 438.10(g)(1) about the grievance system to all providers and subcontractors at the time they enter into a contract.

## 9.5 Record-keeping and Reporting Requirements

Reports of grievances and resolutions shall be submitted to SCDHHS as specified in §§8.3, 9 and 10.2 of this Contract. The Contractor shall not modify the grievance procedure without the prior written approval of SCDHHS.

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#### 10 REPORTING REQUIREMENTS

The Contractor is responsible for complying with all the reporting requirements established by SCDHHS. The Contractor shall provide SCDHHS test media of all required electronic files prior to Contract execution for prior approval. The requirements for electronic files can be found in **MHN Policy and Procedure Guide.** The Contractor shall provide to SCDHHS and any of its designees copies of agreed upon reports generated by the Contractor concerning Medicaid MHN program members and any additional reports as requested in regard to performance under this Contract. SCDHHS will provide the Contractor with the appropriate reporting formats, instructions, submission timetables, and technical assistance when required. All reporting periods are specified in the MHN Policy and Procedure Guide. All reports shall be submitted in accordance with the schedule outlined in §13.3, Deliverables of this Contract.

The Minimum Data Elements and required formats for these reports are outlined in MHN Policy and Procedure Guide. Additional reports may be required in the MCO Policy and Procedure Guide. The Contractor shall certify all submitted data, documents and reports. The certification must attest, based on best knowledge, information, and belief (1) to the accuracy, completeness and truthfulness of the data; and (2) to the accuracy, completeness and truthfulness of all documents and reports required by SCDHHS. The data shall be certified by one of the following: (1) the Contractor's Chief Executive Officer (CEO); (2) the Contractor's Chief Financial Officer (CFO); or (3) an individual who has the delegated authority to sign for, and who reports directly to the CEO or CFO. Certification shall be submitted concurrently with the certified data.

## 10.1 Contractor's Network Providers and Subcontractors

The Contractor shall furnish to SCDHHS or its designee a report of all network providers and subcontractors enrolled in the Contractor's plan. SCDHHS will provide the Contractor with Medicaid provider identification numbers. It shall be the Contractor's responsibility to assure confidentiality of the Medicaid Providers' identification number and indemnity of SCDHHS in accordance with § 13.26 of this Contract. This information shall be provided to SCDHHS on a continuing, updated basis. The SCDHHS is to be provided advance copies of all updates not less than ten (10) working days in advance of distribution. Any provider no longer taking new patients must be clearly identified. Any age restrictions for a provider must be clearly identified. The Minimum Data Elements and required format for this listing may be found in the MHN Policy and Procedure Guide.

#### 10.2 Grievance/Appeal Log Summary Reporting

The Contractor shall log grievance/appeal information regarding all active and resolved grievances/complaint/appeals on a monthly basis and submit quarterly. The Minimum Data Elements and required format are identified in the **MHN Policy and Procedure Guide**.

#### 10.3 Disenrollment Reporting

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The Contractor shall submit to SCDHHS disenrollment requests for approval in accordance with §§6.4 - 6.6. The Contractor shall immediately notify SCDHHS when it obtains knowledge of any Medicaid MHN program member whose enrollment should be terminated. See **MHN Policy and Procedure Guide** for a sample form. SCDHHS will furnish forms to the Contractor upon request.

## 10.4 Quality Assessment and Performance Improvement

The Contractor will submit reports of Quality Assessment and Performance Improvement (QAPI) activities, including, QAPI Work Plan, Plan of Correction (POC), Case Management (CM) activities and Workplan, and Quality Measures documentation in accordance with the periodicity contained in § 11 and MHN Policy and Procedure Guide of this Contract.

## 10.5 Medicaid Enrollment Capacity by Practice Report

Monthly and upon request, the Contractor shall submit a Medicaid Enrollment Capacity by practice report. The Minimum Data Elements' and required format are identified in the MHN Policy and Procedure Guide.

## 10.6 Additional Reports

The Contractor shall prepare and submit any other reports as required and requested by SCDHHS, any of SCDHHS designees, and/or CMS, that is related to the Contractor's duties and obligations under this Contract. Information considered to be of a proprietary nature shall be clearly identified as such by the Contractor at the time of submission.

### 10.7 Ownership Disclosure

Federal laws require full disclosure of ownership, management, and control of Medicaid prepaid health plans (42 CFR 455.100-455.104 (2006, as amended)). Form CMS 1513, Ownership and Control Interest Statement, is to be submitted to SCDHHS with this Contract; then resubmitted prior to implementation for each Contract period or when any change in the Contractor's management, ownership or control occurs. The Contractor agrees to report any changes in ownership and disclosure information to SCDHHS within thirty (30) calendar days prior to the effective date of the change.

#### 10.8 Information Related to Business Transactions

The Contractor agrees to furnish to SCDHHS or to HHS information related to significant business transactions as set forth in 42 CFR 455.105 (2006, as amended). Failure to comply with this requirement may result in termination of this Contract.

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#### 10.9 Information on Persons Convicted of Crimes

The Contractor agrees to furnish SCDHHS or HHS information related to any person convicted of a criminal offense under a program relating to Medicare (Title XVIII) and Medicaid (Title XIX) as set forth in 42 CFR 455.106 (2006, as amended). Failure to comply with this requirement may lead to termination of this Contract.

## 11 QUALITY ASSESSMENT, MONITORING AND REPORTING

## 11.1 Quality Assessment

The Contractor will establish and implement a system of Quality Assessment and Performance Improvement (QAPI) as required by 42 CFR 438.200-438.242 and a Case Management (CM) as required by 42 CFR 456 and stated within the **MCO Policy and Procedure Guide**. The Contractor will have an ongoing Continuous Quality Improvement (CQI) program for the services furnished to its members that meets the requirements of 42 CFR 438.200. The Contractor's Medical Director will be responsible for managing the CQI program The Contractor will submit, annually by December 15, its QAPI Workplan, CM Workplan and Integrity Plan to SCDHHS for review and approval. Any subsequent changes or revisions must be submitted to SCDHHS for approval prior to implementation.

The full scope of QAPI, and CM requirements are outlined in the MCO Policy and Procedure Guide, Quality Assessment and Case Management Requirements.

The Contractor will agree to External Quality Review, review of QAPI / CQI / CM meeting minutes and annual medical audits to ensure that it provides quality and accessible health care to Medicaid MCO program members, in accordance with standards contained in the **MCO Policy and Procedure Guide** and under the terms of this Contract. Such audits shall allow SCDHHS or its duly authorized representative to review individual medical records, identify and collect management data, including but not limited to survey and other information concerning the use of services and the reasons for disenrollment.

It is agreed that the standards by which the Contractor will be surveyed and evaluated will be at the sole discretion and approval of SCDHHS. If deficiencies are identified, the Contractor must formulate a Plan of Correction (POC) incorporating a timetable within which it will correct deficiencies identified by such evaluations and audits. SCDHHS must prior approve the POC and will monitor the Contractor's progress in correcting the deficiencies. See **MCO Policy and Procedure Guide.** 

The Contractor must attain accreditation by a nationally recognized

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organization such as the National Committee for Quality Assurance (NCQA) or the Utilization Review Accreditation Commission (URAC) within a reasonable time period, not to exceed four years from the initial county network approval date. SCDHHS will consider other nationally recognized organizations, but prior approval from the SCDHHS QAPI department must be obtained prior to survey application.

## 11.2 Inspection, Evaluation and Audit of Records

At any time during normal business hours, HHS, the State Auditor's Office, the Office of the Attorney General, General Accounting Office (GAO), Comptroller General, SCDHHS, and/or any of the designees of the above, and as often as they may deem necessary during the contract period and for a period of five (5) years from the expiration date of this Contract (including any extensions to the Contract), shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of this Contract and MHN Policy and Procedure Guide. The Contractor shall make all program and financial records and service delivery sites open to the representative or any designees of the above. HHS, SCDHHS, GAO, the State Auditor's Office, the Office of the Attorney General, and/or the designees of any of the above shall have the right to examine and make copies, excerpts or transcripts from all records, contact and conduct private interviews with Contractor clients and employees, and do on-site reviews of all matters relating to service delivery as specified by this Contract See MHN Policy and Procedure Guide.

The Contractor and all of its subcontractors will make office work space available for any of the above-mentioned entities or their designees when the entities are inspecting or reviewing any records related to the provisions of services under this Contract. If any litigation, claim, or other action involving the records has been initiated prior to the expiration of the five (5) year period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the five (5) year period, whichever is later. This provision is applicable to any subcontractor and must be included in all subcontracts. SCDHHS and/or any designee will also have the right to:

- 11.2.1 Inspect and evaluate the qualifications and certification or licensure of Contractor's subcontractors:
- 11.2.2 Evaluate, through inspection of Contractor and its subcontractor's facilities or otherwise, the appropriateness and adequacy of equipment and facilities for the provision of quality health care to members;
- 11.2.3 Evaluate the Contractor's performance for the purpose of determining compliance with the requirements of the Contract;

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- 11.2.4 Audit and inspect any of Contractor's or its subcontractor's records that pertain to health care or other services performed under this Contract, determine amounts payable under this Contract, or the capacity of the Contractor to bear the risk of financial losses; and
- 11.2.5 Contractor agrees to provide, upon request, all necessary assistance in the conduct of the evaluations, inspections, and audits.
- 11.2.6 The SCDHHS shall monitor enrollment and termination practices and ensure proper implementation of the Contractor's grievance procedures, in compliance with 42 CFR 438.226-438.228 (2006, as amended). SCDHHS and its designee shall have access to all information related to complaints and grievances filed by Medicaid MHN Program members.

The Contractor agrees that all statements, reports and claims, financial and otherwise, shall be certified as true, accurate, and complete, and the Contractor shall not submit for payment purposes those claims, statements, or reports which it knows, or has reason to know, are not properly prepared or payable pursuant to federal and state law, applicable regulations, this Contract, and SCDHHS policy.

## 11.3 Changes Resulting from Monitoring and Audit

The Contractor will be responsible for assuring corrective actions are taken when a Contractor or subcontractor's quality of care is inadequate. SCDHHS reserves the right to suspend enrollment in the plan if it is determined that quality of care is inadequate. See **MHN Policy and Procedure Guide**.

In the event the Contractor fails to complete the actions required by the POC the Contractor will be subject to the sanctions specified in §13.5.

#### 11.4 Medical Records Requirements

The Contractor will require network providers/subcontractors to maintain up-to-date medical records at the site where medical services are provided for each Medicaid MHN program member enrolled under this Contract. Each member's record must be legible and maintained in detail consistent with good medical and professional practice which permits effective internal and external quality review and/or medical audit and facilitates an adequate system of follow-up treatment. The Contractor shall ensure within its own provider network that SCDHHS representatives or its designee shall have immediate and complete access to all records pertaining to the health care services provided to Medicaid MHN program members. Medical record requirements are further defined in the **MHN Policy and Procedure Guide**.

#### 11.5 Record Retention

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All records originated or prepared in connection with Contractor's performance of its obligations under this Contract, including but not limited to, working papers related to the preparation of fiscal reports, medical records, progress notes, charges, journals, ledgers and electronic media will be retained and safeguarded by the Contractor and its subcontractors in accordance with the terms and conditions of this Contract.

The Contractor further agrees to retain all financial and programmatic records, supporting documents, statistical records and other records of members relating to the delivery of care or service under this Contract, and as further required by SCDHHS, for a period of five (5) years from the expiration date of the Contract, including any Contract extension(s). If any litigation, claim, or other actions involving the records have been initiated prior to the expiration of the five (5) year period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the five (5) year period, whichever is later. If the Contractor stores records on microfilm or microfiche, Contractor hereby agrees to produce at Contractor's expense, legible hard copy records upon the request of state or federal authorities, within fifteen (15) calendar days of the request.

This provision is applicable to any subcontractor and must be included in all subcontracts.

## 12 SCDHHS RESPONSIBILITIES

#### 12.1 SCDHHS Contract Management

The SCDHHS will be responsible for the administrative oversight of the Medicaid MHN Program. As appropriate, SCDHHS will provide clarification of Medicaid MHN Program and Medicaid policy, regulations and procedures. The SCDHHS will be responsible for management of this Contract. All Medicaid policy decision making or Contract interpretation will be made solely by SCDHHS. The management of this Contract will be conducted in the best interests of SCDHHS and the Medicaid MHN Program members. See §3 of this Contract for more detailed information on SCDHHS' contract management responsibilities.

Whenever SCDHHS is required by the terms of this Contract to provide written notice to the Contractor, such notice will be signed by the Director of SCDHHS or his designee.

#### 12.2 Method of Reimbursement

SCDHHS will pay the Contractor a prospective case management/care coordination fee of Ten Dollars (\$10.00) per member per month (PMPM) as payment in full for the services described for the period. Any Care Coordination PMPM fee that the CSO chooses to pay to the participating practices shall be paid from this prospective PMPM. Any merit-based bonuses, not dependent on cost savings that the CSO chooses to pay to

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the participating practices shall be paid from this prospective PMPM. Any merit bonus or incentive payment made to participating practices must be in accordance/compliance with the requirements set forth in 42CFR §§ 422.208 and 422.210. Detailed information on Physician Incentive Plan requirements may be found in the MHN Policy and Procedure Guide.

SCDHHS will share documented cost savings with the Network as an incentive. If the Network fails to achieve cost savings, SCDHHS will impose a penalty and a portion, if not all of the prospective care coordination fee payments must be refunded to the SCDHHS. SCDHHS will conduct periodic cost reconciliation. At a minimum, cost reconciliation shall be conducted semi-annually. A detailed description of the shared savings formula is attached as Appendix B.

## 12.3 Payment in Full

Payment by SCDHHS for services to a beneficiary under this contract, plus any co-payment required by SCDHHS to be paid by the beneficiary, shall constitute payment in full to the Contractor and the Contractor shall not bill, request, demand, solicit or in any manner receive or accept payment or contributions from the beneficiary or any other person, family member, relative, organization or entity for care or services to a beneficiary except as may otherwise be allowed under federal regulations or in accordance with SCDHHS policy. Any collection of payment or deposits in violation of this Section shall be grounds for termination of this contract and reimbursement for any services to beneficiaries made after such collection or attempt to collect may be denied by SCDHHS and shall be subject to recoupment for any beneficiary payment made.

## 12.4 Notification of Medicaid MHN Program Policy and Procedures

SCDHHS will provide the Contractor with updates to appendices, information and interpretation of all pertinent federal and state Medicaid regulations, Medicaid MHN Program policies, procedures and guidelines affecting the provision of services under this Contract. The Contractor will submit written requests to SCDHHS for additional clarification, interpretation or other information in a grid format specified by SCDHHS. Provision of such information does not relieve the Contractor of its obligation to keep informed of applicable federal and state laws related to its obligations under this Contract.

#### 12.5 Provider Participation

SCDHHS will notify the Contractor in writing, of providers who have been suspended or terminated from participation in the Medicaid/Medicare Program monthly. Once a month SCDHHS will notify the Contractor of current Medicaid providers to assist the Contractor in care coordination and encounter data reporting.

#### 12.6 Quality Assessment and Monitoring Activities

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SCDHHS is responsible for monitoring the Contractor's performance to assure the Contractor is in compliance with the Contract provisions and the **MCO Policy and Procedure Guide**. SCDHHS or its designee shall coordinate with the Contractor to establish the scope of review, the review site, relevant time frames for obtaining information, and the criteria for review.

SCDHHS or its designee will at least annually monitor the operation of the Contractor for compliance with the provisions of this Contract, the **MCO Policy and Procedure Guide**, and applicable federal and state laws and regulations.

## 12.6.1 Quality Measures and HEDIS

The Contractor is required to conduct quality of care outcome studies which include quality measures for HEDIS, prenatal care, newborns, childhood immunizations, asthma, ER utilization and EPSDT services. The **MHN Policy and Procedure Guide**, Quality Measures, lists the SCDHHS quality measures. SCDHHS may impose liquidated damages, sanctions and/or restrict enrollment pending attainment of acceptable quality of care.

## 12.6.2 Request for Plan of Correction

The SCDHHS will monitor the Contractor's quality care outcome activities and corrective actions taken as specified in the Medicaid MHN Program Quality Assessment Plan in the MHN Policy and Procedure Guide.

The Contractor must make provisions for prompt response to any detected deficiencies or contract violations and for the development of corrective action initiatives relating to this contract.

#### 12.6.3 External Quality Review

The SCDHHS will perform periodic medical audits through contractual arrangements to determine if the Contractor furnished quality and accessible health care to Medicaid MHN program members in compliance with this contract and with the regulations pertaining to Primary Care Case Management programs found in 42 CFR 438. SCDHHS will contract with an External Quality Review Organization (EQRO) to perform the periodic medical audits and external independent reviews. The **MHN Policy and Procedure Guide** and the Medicaid Managed Care External Review Services lists SCDHHS external quality assessment evaluation requirements.

## 12.7 Marketing

SCDHHS, and/or its designee shall have the right to approve, disapprove or require modification of all marketing plans, materials, and activities,

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enrollment and member handbook materials developed by the Contractor under this Contract and prior to implementation/distribution by the Contractor. See Section 7 of this Contract and the **MHN Policy and Procedure Guide** for guidance.

## 12.8 Grievance/Appeals

SCDHHS shall have the right to approve, disapprove or require modification of all grievance procedures submitted with this Contract. SCDHHS requires the Contractor to meet and/or exceed the Medicaid MHN Program grievance standards as outlined in §9.

## 12.9 Training

SCDHHS will conduct provider training and workshops on Medicaid MHN Program policy and procedures as deemed appropriate for MHN Contractors.

## 12.10 Federal Fund Restrictions

SCDHHS will transmit to the Contractor, on a regular basis, information regarding individuals prohibited from receiving Federal funds who appear on the OIG electronic database.

## 13 TERMS AND CONDITIONS

The Contractor agrees to comply with all state and federal laws, regulations, and policies as they exist or as amended that are or may be applicable to this Contract, including those not specifically mentioned in this section. Any provision of this Contract which is in conflict with Federal statutes, regulations, or CMS policy guidance is hereby amended to conform to the provisions of those laws, regulations, and Federal policy. Such amendment of the Contract will be effective on the effective date of the statutes, regulations, or policy statement necessitating it, and will be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties. The Contractor may request SCDHHS to make policy determinations required for proper performance of the services under this Contract. The Contractor shall be entitled to rely upon and act in accordance with such policy determinations when such determinations are made in writing and signed by the Director, SCDHHS.

#### 13.1 Applicable Laws and Regulations

The Contractor agrees to comply with all applicable federal and state laws and regulations including Constitutional provisions regarding due process and equal protection under the laws and including but not limited to:

13.1.1 Title 42 Code of Federal Regulations (CFR) Chapter IV, Subchapter C (Medical Assistance Programs);

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- 13.1.2 S.C. Code Ann. § 38-33-10 <u>et. seq.</u> (Supp. 2000, as amended) and 25 S.C. Code Ann. Regs. 69-22 (Supp. 2000, as amended);
- 13.1.3 All applicable standards, orders, or regulations issued pursuant to the Clean Air Act of 1970 as amended (42 U.S.C. 7401, et seq.) and 20 USC §6082(2) of the Pro-Children Act of 1994, as amended (P.L. 103-227);
- Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. 2000d) and regulations issued pursuant thereto, 45 CFR part 80; In accordance with Title VI of the Civil Rights Act of 1964 (42U.S.C. 2000d et seq.) and its implementing regulation at 45 C.F.R. Part 80, the Provider must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this agreement.
- 13.1.5 Title VII of the Civil Rights Act of 1964, as amended (42 U.S.C. 2000e) in regard to employees or applicants for employment;
- 13.1.6 Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 794, which prohibits discrimination on the basis of handicap in programs and activities receiving or benefiting from federal financial assistance, and regulations issued pursuant thereto, 45 CFR Part 84;
- 13.1.7 The Age Discrimination Act of 1975, as amended, 42 U.S.C 6101 et seg., which prohibits discrimination on the basis of age in programs or activities receiving or benefiting from federal financial assistance;
- 13.1.8 The Omnibus Budget Reconciliation Act of 1981, as amended, P.E.97-35, which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefiting from federal financial assistance;
- 13.1.9 The Balanced Budget Act of 1997, as amended, P.L. 105-33 and the Balanced Budget Refinement Act of 1999, as amended, H.R. 3426.
- 13.1.10 Americans with Disabilities Act, as amended, 42 U.S.C. §12101 et seq., and regulations issued pursuant thereto, 28 CFR Parts 35, 36;
- 13.1.11 Sections 1128 and 1156 of the Social Security Act, as amended, relating to exclusion of Contractors for fraudulent

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or abusive activities involving the Medicare and/or Medicaid Program;

- Drug Free Workplace Acts, S.C. Code Ann. §§44-107-10 et seq. (Supp. 2000, as amended), and the Federal Drug Free Workplace Act of 1988 as set forth in 45 CFR Part 82, (2006, as amended); and
- Debarment/Suspension, as contained in 45 CFR Part 76 (2006, as amended).
- 13.1.14 Title IX of the Education Amendments of 1972 regarding education programs and activities;

## 13.2 <u>Termination</u>

This Contract shall be subject to the following termination provisions. SCDHHS or its designee will give the Contractor written notice that the Contractor has failed to perform its contractual undertakings and may, at the discretion of SCDHHS, give the Contractor a specific time period in which to correct the deficiencies, unless other provisions in this section demand otherwise, before an actual notice of termination is issued. If SCDHHS determines that the Contractor has satisfactorily implemented corrective action, a notice of termination will not be issued. If SCDHHS determines that the Contractor has not satisfactorily corrected the problem(s), a notice of termination will be issued. SCDHHS will provide Contractor with a written Notice of Intent to Terminate the contract between SCDHHS and the Contractor. The Notice of Intent to Terminate will include the date, time and location of a fair hearing before the SCDHHS Division of Appeals and Hearings. In the event of such termination, it is agreed that neither party shall be relieved from any financial obligations each may owe to the other. SCDHHS or its designee will assume responsibility for informing all affected members of the reasons for their termination from the Contractor.

## 13.2.1 Termination Under Mutual Agreement

Under mutual agreement, SCDHHS and the Contractor may terminate this Contract for any reason if it is in the best interest of SCDHHS and the Contractor. Both parties will sign a notice of termination which shall include, the date of termination, conditions of termination, and extent to which performance of work under this Contract is terminated.

## 13.2.2 Termination by SCDHHS for Breach

In the event that SCDHHS determines that the Contractor, or any of the Contractor's subcontractors fails to perform its contracted duties and responsibilities in a timely and proper manner, or if the Contractor shall violate any of the terms of this Contract, SCDHHS may terminate this Contract upon thirty (30) calendar days notice to

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the Contractor. Such notice will specify the manner in which the Contractor or its subcontractor(s) has failed to perform its contractual responsibilities. If SCDHHS determines that the Contractor and/or its subcontractor(s) have satisfactorily implemented corrective action within the thirty (30) calendar day notice period, the notice of termination may be withdrawn at the discretion of SCDHHS.

SCDHHS may terminate this Contract immediately if it is determined that actions by the Contractor or its subcontractor(s) pose a serious threat to the health of Medicaid MHN Program members enrolled in the Contractor's plan.

The Contractor will be paid for any outstanding monies due less any assessed damages. If damages exceed monies due, collection can be made from the Contractor's Fidelity Bond, Errors and Omissions Insurance, or any insurance policy or policies required under this Contract. The rights and remedies of the SCDHHS provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Contract.

## 13.2.3 Termination for Unavailability of Funds

In the event that federal and/or state funds to finance this Contract become unavailable after the effective date of this Contract, or prior to the anticipated contract expiration date, SCDHHS may terminate the Contract without penalty. This notification will be made in writing. Availability of funds shall be determined solely by SCDHHS.

# 13.2.4 Termination for Contractor Insolvency, Bankruptcy, Instability of Funds

The Contractor's insolvency or the filing of a petition in bankruptcy by or against the Contractor shall constitute grounds for termination for cause. If the SCDHHS determines the Contractor has become financially unstable, SCDHHS will immediately terminate this Contract upon written notice to the Contractor effective the close of business on the date specified.

#### 13.2.5 Termination for Convenience

SCDHHS may terminate this Contract for convenience and without cause upon thirty (30) calendar days written notice. Said termination shall not be a breach of contract by SCDHHS and SCDHHS shall not be responsible to the Contractor or any other party for any costs, expenses, or damages occasioned by said termination, i.e., without penalty.

#### 13.2.6 Termination by the Contractor

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The Contractor shall give SCDHHS written notice of intent to terminate this Contract ninety (90) calendar days prior to the date of receipt of written notice by SCDHHS. Such written notice may be either hand-delivered to SCDHHS or may be mailed by certified mail, return receipt requested. The ninety (90) calendar days written notice shall specify the last date of operation, such date being at least ninety (90) calendar days termination from documented receipt of the notice of termination. The Contractor shall comply with all terms and conditions stipulated in this Contract during the close out period.

## 13.2.7 Termination for Noncompliance with the Drug Free Workplace Act

In accordance with S.C. Code Ann §44-107-60 (Supp. 2000, as amended), this Contract is subject to immediate termination, suspension of payment, or both if the Contractor fails to comply with the terms of the Drug Free Workplace Act.

## 13.2.8 Termination for Cause

The Contractor is subject to termination, unless the Contractor can demonstrate changes of ownership or control, when:

 A person with a direct or indirect ownership interest in the Contractor

a. Has been convicted of a criminal offense under Sections 1128 (a) and 1128 (b)(1), (2), or (3) of the Social Security Act, in accordance with §1002.203 of 42 CFR.

b. Has had civil monetary penalties or assessment imposed under Section 1128A of the Act; or

c. Has been excluded from participation in Medicare or any State health care program; and

d. Has a direct or indirect ownership interest or any combination therefore of 5% or more, is an officer if the Contractor is organized as a corporation or partner of the contractor if it is organized as a partnership; is an agent or is a managing employee.

The Contractor has directly or indirectly a substantial contractual relationship with an excluded individual or entity. "Substantial contractual relationship" is defined as any direct or indirect business transactions that amount in a single fiscal year to more than \$25,000 or 5% of the MHN's total operating expenses, whichever is less.

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#### 13.2.9 Termination Procedures

The party initiating the termination shall render written notice of termination to the other party by certified mail, return receipt requested, or in person with proof of delivery. The notice of termination shall specify the provision of this Contract giving the right to terminate; the circumstances giving rise to termination; and the date on which such termination shall become effective. When applicable, SCDHHS shall proceed with termination in accordance with § 13.2 and § 13.5.10 of this Contract.

Upon receipt of notice of termination, and subject to the provisions stated herein, on the date and to the extent specified in the notice of termination, the Contractor shall:

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13.2.9.1	Stop work under the Contract, but not before the termination date;
13.2.9.2	Terminate all marketing procedures and subcontracts
13.2.9.2	related to marketing;
13.2.9.3	Assign to SCDHHS in the manner and extent directed
1921 1887	by SCDHHS all the rights, title and interest of the
	Contractor for the performance of the subcontracts to

be determined as needed in which case SCDHHS shall have the right, in its discretion, to resolve or pay any of the claims arising out of the termination of such agreements and subcontracts. The Contractor shall supply all information necessary for reimbursement of any outstanding Medicaid claims; Complete the performance of such part of the Contract which shall have not been terminated under

13.2.9.5 Take such action as may be necessary, or as SCDHHS may direct, for the protection of property related to this Contract which is in possession of the Contractor in which SCDHHS has or may acquire an interest:

the notice of termination;

13.2.9.6 In the event the Contract is terminated by SCDHHS, the Contractor shall continue to serve or arrange for provision of services to the members of the Contractor until the effective date of termination. During this transition period, SCDHHS shall continue to pay the applicable capitation rate(s). Members shall be given written notice of the State's intent to terminate the contract and shall be allowed to disenroll immediately without cause;

13.2.9.7 Provide all necessary assistance to SCDHHS in transitioning members out of the Contractor's plan to the extent specified in the notice of termination. Such assistance shall include, but not be limited to, the forwarding of all medical or financial records; facilitation and scheduling of medically necessary

13.2.9.4

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appointments for care and services; and identification of chronically ill, high risk, hospitalized, and pregnant members in their last four (4) weeks of pregnancy; The transitioning of records, whether medical or financial, related to the Contractor's activities undertaken pursuant to this Contract shall be in a form usable by SCDHHS or any party acting on behalf of SCDHHS and shall be provided at no expense to SCDHHS or another Contractor acting on behalf of SCDHHS:

13.2.9.8

Not receive its prepaid payment for any requests for payment submitted after the aforesaid Contract ends. Any payments due under the terms of this Contract may be withheld until SCDHHS receives from the Contractor all written and properly executed documents as required by the written instructions of SCDHHS.

## 13.3 <u>Deliverables</u>

The Contractor shall submit all deliverables or reports required by this Contract and detailed in the MHN Policy and Procedure Guide, Index Of Required Reports And Forms, at the frequency established by SCDHHS.

<u>Deliverables</u>	Date Agreed Upon
Daily Reports	Within two (2) working days.
Weekly Reports	Wednesday of the following week.
Monthly Reports	15th of the following month.
Quarterly Reports	30th of the following month.

Annual Reports

Ninety (90) calendar days after the end of the year.

On Request/Additional Reports

Within three (3) working days from the date of request unless otherwise specified by SCDHHS.

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#### 13.4 Use of Data

SCDHHS shall have unlimited rights to use, disclose, or duplicate, for any purpose, all information and data developed, derived, documented, or furnished by the Contractor resulting from this Contract.

## 13.5 Sanctions

If SCDHHS determines that the Contractor has violated any provision of this Contract, or the applicable statutes or rules governing Medicaid prepaid health plans, the SCDHHS may impose, against the Contractor, sanctions. SCDHHS shall notify the Contractor and CMS in writing of its intent to impose sanctions and explain the Contractor's due process rights. Sanctions shall be in accordance with §1932 of the Social Security Act (42 USC 1396u-2) and 42 CFR §438.700-730 (2006, as amended) and may include any of the following sanctions:

- 13.5.1 Suspension of the Contractor's acceptance of applications for Medicaid enrollment;
- 13.5.2 Suspension or revocation of payments to the Contractor for Medicaid beneficiaries/eligibles enrolled during the sanction period; including default of the enrollment of Medicaid members. This violation may result in recoupment of capitated payment.
- 13.5.3 Suspension of all marketing activities permitted under this Contract;
- 13.5.4 Imposition of a fine of up to Ten Thousand Dollars (\$10,000.00) for each marketing/enrollment violation, in connection with any one audit or investigation;
- 13.5.5 Termination pursuant to §13.2.2 of this Contract;
- 13.5.6 Non-renewal of the Contract pursuant to §13.7 of this Contract;
- 13.5.7 Appointment of temporary management in accordance with § 1932(e)(2)(B) of SSA (42 U.S.C. 1396u-2) (2001, as amended) and 42 CFR §438.702. If the State finds that the MHN has repeatedly failed to meet substantive requirements in §1903(m) or §1932 of the Social Security Act 42 USC 1396u-2, the State must impose temporary management and grant members the right to terminate enrollment without cause, notifying the affected members of their right to terminate enrollment.
- 13.5.8 Civil money penalties in accordance with §1932 of the Social Security Act 42 USC 1396u-2.
- 13.5.9 Permit individuals enrolled in the Contractor's plan to be disenrolled without cause. SCDHHS may suspend or default all enrollment of Medicaid beneficiaries after the date the Secretary

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- or SCDHHS notifies the Contractor of an occurrence under §1903(m) or section 1932(e) of the Social Security Act.
- 13.5.10 Terminate contract if the Contractor has failed to meet the requirements of section 1903(m), 1905(t)(3) or 1932(e) of the Social Security Act and offer the Contractor's Medicaid members an opportunity to enroll with other Contractors to allow members to receive medical assistance under the State Plan. SCDHHS shall provide the Contractor a hearing before the SCDHHS Division of Appeals and Hearings before termination occurs. SCDHHS will notify the Medicaid members enrolled in the Contractor's plan of the hearing and allow the Medicaid eligibles to disenroll, if they choose, without cause.
- 13.5.11 Imposition of a fine of up to Twenty-five Thousand Dollars (\$25,000) for each occurrence of the Contractor's failure to substantially provide medically necessary items and services that are required to be provided to a member covered under the contract.
- 13.5.12 Imposition of a fine of up to Fifteen Thousand Dollars (\$15,000) per individual not enrolled and up to a total of One Hundred Thousand Dollars (\$100,000) per each occurrence, when the Contractor acts to discriminate among members on the basis of their health status or their requirements for health care services. Such discrimination includes, but is not limited to, expulsion or refusal to re-enroll an individual, except as permitted by Title XIX, or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the entity by eligible individuals whose medical condition or history indicates a need for substantial future medical services.
- 13.5.13 Imposition of a fine as high as double the excess amount charged to the Medicaid members by the Contractor for premiums or charges in excess of the premiums or charges permitted under Title XIX.
- 13.5.14 SCDHHS may impose sanctions as outlined in the **MHN Policy** and **Procedure Guide** if the Contractor fails to comply with the Physician Incentive Plan requirements.
- 13.5.15 SCDHHS may impose sanctions as outlined above if the Contractor misrepresents or falsifies information that it furnishes to CMS, to the State or to a member, potential member or health care provider.

#### 13.6 Duration of the Sanction

Unless the duration of a sanction is specified, a sanction will remain in effect until SCDHHS is satisfied that the basis for imposing the sanction

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has been corrected. SCDHHS will notify CMS when a sanction has been lifted.

### 13.7 Non-Renewal

This Contract shall be renewed only upon mutual consent of the parties. Either party may decline to renew the Contract for any reason. The parties expressly agree there is no property right in this Contract.

## 13.8 Plan of Correction Required (Contract Non-Compliance)

The Contractor and its subcontractors shall comply with all requirements of this Contract. In the event SCDHHS or its designee finds that the Contractor and/or its subcontractors failed to comply with any requirements of this Contract, the Contractor shall be required to submit a Plan of Correction to SCDHHS outlining the steps it will take to correct any deficiencies and/or non-compliance issues identified by SCDHHS in the Notice of Corrective Action. SCDHHS shall have final approval of the Contractor's Plan of Correction.

The Contractor's Plan of Correction shall be submitted to SCDHHS within the time frame specified in the Notice of Corrective Actions. The Contractor and/or its subcontractor(s) shall implement the corrective actions as approved by SCDHHS and shall be in compliance with the Contract requirements noted within the time frame specified in the Notice of Corrective Action. The Contractor and/or its subcontractors shall be available and cooperate with SCDHHS and/or its designee as needed in implementing the approved corrective actions.

Failure of the Contractor and/or its subcontractor(s) to implement and follow the Plan of Correction as approved by SCDHHS shall subject the Contractor to the actions, including but not limited to, in §§13.2, including all subsections, 13.3 and 13.5 including all subsections of this Contract.

#### 13.9 Inspection of Records

The Contractor shall make all program and financial records and service delivery sites open to the HHS, SCDHHS, GAO, State Auditor's Office, Office of the Attorney General, Comptroller General, or their designee. HHS, SCDHHS, GAO, the State Auditor's Office, the Office of the Attorney General, the Comptroller General and/or their designees shall have the right to examine and make copies, excerpts or transcripts from all records, contact and conduct private interviews with Contractor clients and employees, and do on-site reviews of all matters relating to service delivery as specified by this Contract.

#### 13.10 Non-Waiver of Breach

The failure of SCDHHS at any time to require performance by the Contractor of any provision of this Contract, or the continued payment of the Contractor by SCDHHS, shall in no way affect the right of SCDHHS to

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enforce any provision of this Contract; nor shall the waiver of any breach of any provision thereof be taken or held to be a waiver of any succeeding breach of such provision or as a waiver of the provision itself. No covenant, condition, duty, obligation, or undertaking contained in or made a part of this Contract shall be waived except by the written agreement of the parties and approval of CMS, if applicable.

Waiver of any breach of any term or condition in this Contract shall not be deemed a waiver of any prior or subsequent breach. No term or condition of this Contract shall be held to be waived, modified, or deleted except by an instrument, in writing, signed by the parties hereto.

## 13.11 Non-Assignability

No assignment or transfer of this Contract or of any rights hereunder by the Contractor shall be valid without the prior written consent of SCDHHS.

## 13.12 Legal Services

No attorney-at-law shall be engaged through use of any funds provided by SCDHHS pursuant to the terms of this Contract. Further, with the exception of attorney's fees awarded in accordance with S.C. Code Ann. §15-77-300 (2000, as amended), SCDHHS shall under no circumstances become obligated to pay an attorney's fee or the costs of legal action to the Contractor. This covenant and condition shall apply to any and all suits, legal actions, and judicial appeals of whatever kind or nature to which the Contractor is a party.

## 13.13 Venue of Actions

Any and all suits or actions for the enforcement of the obligations of this Contract and for any and every breach thereof, or for the review of a SCDHHS final agency decision with respect to this Contract or audit disallowances, and any judicial review sought thereon and brought pursuant to the S.C. Code Ann. § 1-23-380 (2000, as amended) shall be instituted and maintained in any court of competent jurisdiction in the County of Richland, State of South Carolina.

## 13.14 Attorney's Fees

In the event that SCDHHS shall bring suit or action to compel performance of or to recover for any breach of any stipulation, covenant, or condition of this Contract, the Contractor shall and will pay to SCDHHS such attorney's fees as the court may adjudge reasonable in addition to the amount of judgment and costs.

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#### 13.15 Independent Contractor

It is expressly agreed that the Contractor and any subcontractors and agents, officers, and employees of the Contractor or any subcontractors in the performance of this Contract shall act in an independent capacity and not as officers and employees of SCDHHS or the State of South Carolina. It is further expressly agreed that this Contract shall not be construed as a partnership or joint venture between the Contractor or any subcontractor and SCDHHS and the State of South Carolina.

## 13.16 Governing Law and Place of Suit

It is mutually understood and agreed that this Contract shall be governed by the laws of the State of South Carolina both as to interpretation and performance. Any action at law, suit in equity, or judicial proceeding for the enforcement of this Contract or any provision thereof shall be instituted only in the courts of the State of South Carolina.

## 13.17 Severability

If any provision of this Contract (including items incorporated by reference) is declared or found to be illegal, unenforceable, or void, then both SCDHHS and Contractor shall be relieved of all obligations arising under such provision. If the remainder of this Contract is capable of performance, it shall not be affected by such declaration or finding and shall be fully performed. In addition, if the laws or regulations governing this Contract should be amended or judicially interpreted as to render the fulfillment of the Contract impossible or economically infeasible, both SCDHHS and the Contractor will be discharged from further obligations created under the terms of the Contract. To this end, the terms and conditions defined in this Contract can be declared severable.

#### 13.18 Copyrights

If any copyrightable material is developed in the course of or under this Contract, SCDHHS shall have a royalty free, non-exclusive, and irrevocable right to reproduce, publish, or otherwise use the work for SCDHHS purposes.

#### 13.19 Subsequent Conditions

The Contractor shall comply with all requirements of this Contract and SCDHHS shall have no obligation to enroll any MHN program Members into the Contractor's plan until such time as all of said requirements have been met.

## 13.20 <u>Incorporation of Schedules/Appendices</u>

All schedules/appendices referred to in this Contract are attached hereto, are expressly made a part hereof, and are incorporated as if fully set forth herein.

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#### 13.21 Titles

All titles used herein are for the purpose of clarification and shall not be construed to infer a contractual construction of language.

## 13.22 <u>Safeguarding Information</u>

The Contractor shall establish written safeguards which restrict the use and disclosure of information concerning members or potential members to purposes directly connected with the performance of this Contract. The Contractor's written safeguards shall:

- 13.22.1 Be comparable to those imposed upon the SCDHHS by 42 CFR Part 431, Subpart F (2005, as amended) and S.C. Code R. 126-170 et seq. (Supp. 2000, as amended);
- 13.22.2 State that the Contractor will identify and comply with any stricter state or federal confidentiality standards which apply to specific types of information or information obtained from outside sources;
- 13.22.3 Generally, require the written consent of the member or potential member before disclosure of information about him or her;
- Not prohibit the release of statistical or aggregate data which cannot be traced back to particular individuals; and
- 13.22.5 Specify appropriate personnel actions to sanction violators.

#### 13.23 Release of Records

The Contractor shall release medical records of members, as may be authorized by the member, as may be directed by authorized personnel of SCDHHS, appropriate agencies of the State of South Carolina, or the United States Government. Release of medical records shall be consistent with the provisions of confidentiality as expressed in this Contract.

#### 13.24 Fraudulent Activity

The Contractor shall report to SCDHHS any cases of suspected Medicaid fraud or abuse by its members, employees, or subcontractors. The Contractor shall report such suspected fraud or abuse in writing as soon as practicable after discovering suspected incidents. The Contractor shall report the following fraud and abuse information to SCDHHS:

(a) The number of complaints of fraud and abuse made to SCDHHS that warrant preliminary investigation.

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- (b) For each case of suspected provider fraud and abuse that warrants a full investigation:
  - (1) the provider's name and number
  - (2) the source of the complaint
  - (3) the type of provider
  - (4) the nature of the complaint
  - (5) the approximate range of dollars involved
  - (6) the legal and administrative disposition of the case

## 13.25 Integration

This Contract shall be construed to be the complete integration of all understandings between the parties hereto. No prior or contemporaneous addition, deletion, or other amendment hereto shall have any force or effect whatsoever unless embodied herein in writing. No subsequent novation, renewal, addition, deletion, or other amendment hereto shall have any force or effect unless embodied in a written amendment executed and approved by the parties.

## 13.26 Hold Harmless

The Contractor shall indemnify, defend, protect, and hold harmless SCDHHS and any of its officers, agents, and employees from:

- Any claims for damages or losses arising from services rendered by any subcontractor, person, or firm performing or supplying services, materials, or supplies for the Contractor in connection with the performance of this Contract;
- Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of State or Federal Medicaid regulations or legal statutes, by Contractor, its officers, employees, or subcontractors in the performance of this Contract;
- Any claims for damages or losses resulting to any person or firm injured or damaged by Contractor, its officers, employees, or subcontractors by the publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under this Contract in a manner not authorized by the Contract or by Federal or State regulations or statutes:
- Any failure of the Contractor, its officers, employees, or subcontractors to observe the federal or state laws, including, but not limited to, labor laws and minimum wage laws:
- 13.26.5 Any claims for damages, losses, or costs associated with legal expenses, including, but not limited to, those incurred by or on behalf of SCDHHS in connection with the defense

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of claims for such injuries, losses, claims, or damages specified above;

13.26.6 Any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against SCDHHS or their agents, officers or employees, through the intentional conduct, negligence or omission of the Contractor, its agents, officers, employees or subcontractors.

In the event that, due to circumstances not reasonably within the control of Contractor or SCDHHS, (i.e., a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection), neither the Contractor, SCDHHS, or subcontractor(s), will have any liability or obligation on account of reasonable delay in the provision or the arrangement of covered services; provided, however, that so long as the Contractor's certificate of authority remains in full force and effect, the Contractor shall be liable for the covered services required to be provided or arranged for in accordance with this Contract.

## 13.27 Hold Harmless as to the Medicaid MHN Program Members

In accordance with the requirements of S.C Code Ann. § 38-33-130(b) (Supp. 2001), as amended, and as a condition of participation as a health care provider, the Contractor hereby agrees not to bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have recourse against, Medicaid MHN program members of Contractor, or persons acting on their behalf, for health care services which are rendered to such members by the Contractor and its subcontractors, and which are covered benefits under the members evidence of coverage. provision applies to all covered health care services furnished to the Medicaid MHN program member for which the State does not pay the Contractor of the State or the Contractor does not pay the individual or health care provider that furnishes the services under a contractual, referred, or other arrangement during the time the member is enrolled in, or otherwise entitled to benefits promised by the Contractor. Contractor further agrees that the Medicaid MHN program member shall not be held liable for payment for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the member would owe if the MHN provided the service directly. The Contractor agrees that this provision is applicable in all circumstances including, but not limited to, non-payment by Contractor and insolvency of Contractor. The Contractor further agrees that this provision shall be construed to be for the benefit of Medicaid MHN Program members of Contractor, and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the Contractor and such members, or persons acting on their behalf.

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### 13.28 Non-Discrimination

The Contractor agrees that no person, on the grounds of handicap, age, race, color, religion, sex, or national origin, shall be excluded from participation in, or be denied benefits of, or be otherwise subjected to discrimination in the performance of this Contract or in the employment practices of the Contractor. The Contractor shall upon request show proof of such non-discrimination, and shall post in conspicuous places, available to all employees and applicants, notices of non-discrimination. This provision shall be included in all subcontracts.

# 13.29 Confidentiality of Information

The Contractor shall assure that all material and information, in particular information relating to members or potential members, which is provided to or obtained by or through the Contractor's performance under this Contract, whether verbal, written, electronic file, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under state and federal laws. The Contractor shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights under this Contract.

All information as to personal facts and circumstances concerning members or potential members obtained by the Contractor shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of SCDHHS or the member/potential member, provided that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning members/potential members shall be limited to purposes directly connected with the administration of this Contract.

#### 13.30 Employment of Personnel

In all hiring or employment made possible by or resulting from this Contract, the Contractor agrees that (1) there shall be no discrimination against any employee or applicant for employment because of handicap, age, race, color, religion, sex, or national origin, and that (2) affirmative action shall be taken to ensure that applicants are employed and that employees are treated during employment without regard to their handicap, age, race, color, religion, sex, or national origin. requirement shall apply to, but not be limited to, the following: employment, upgrading, demotion, transfer, recruitment or recruitment advertising, layoff, termination, rates of pay or other forms of compensation, and selection for training including apprenticeship. The Contractor further agrees to give public notice in conspicuous places available to employees and applicants for employment setting forth the provisions of this section. All solicitations or advertisements for employees shall state that all qualified applicants will receive consideration for employment without regard to handicap, age, race, color,

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religion, sex, or national origin. All inquiries made to the Contractor concerning employment shall be answered without regard to handicap, age, race, color, religion, sex, or national origin. All responses to inquiries made to the Contractor concerning employment made possible as a result of this Contract shall conform to federal, state, and local regulations.

## 13.31 Political Activity

None of the funds, materials, property, or services provided directly or indirectly under this Contract shall be used for any partisan political activity, or to further the election or defeat of any candidate for public office, or otherwise in violation of the provisions of the "Hatch Act".

## 13.32 Force Majeure

The Contractor shall not be liable for any excess costs if the failure to perform the Contract arises out of causes beyond the control and without the fault or negligence of the Contractor. Such causes may include, but are not restricted to acts of God or of the public enemy, acts of the Government in either its sovereign or contractual capacity, fires, floods, epidemics, quarantine restrictions, strikes, freight embargoes, and unusually severe weather; but in every case the failure to perform must be beyond the control and without the fault or negligence of the Contractor. If the failure to perform is caused by default of a subcontractor, and if such default arises out of causes beyond the control of both the Contractor and subcontractor, and without the fault or negligence of either of them, the Contractor shall not be liable for any excess costs for failure to perform, unless the supplies or services to be furnished by the subcontractor were obtainable from other sources in sufficient time to permit the Contractor to meet the required delivery schedule.

SCDHHS shall not be liable for any excess cost to the Contractor for SCDHHS's failure to perform the duties required by this Contract if such failure arises out of causes beyond the control and without the result of fault or negligence on the part of SCDHHS. In all cases, the failure to perform must be beyond the control without the fault or negligence of SCDHHS.

#### 13.33 Conflict of Interest

All State employees shall be subject to the provisions of S.C. Code Ann. § 8-13-100 and §8-13-310, et seq. (Supp. 2000, as amended).

The Contractor represents and covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder. The Contractor further covenants that, in the performance of the Contract, no person having any such known interests shall be employed.

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## 13.34 <u>Safety Precautions</u>

SCDHHS and USHHS assume no responsibility with respect to accidents, illnesses, or claims arising out of any activity performed under this Contract. The Contractor shall take necessary steps to ensure or protect its clients, itself, and its personnel. The Contractor agrees to comply with all applicable local, state, and federal occupational and safety acts, rules, and regulations.

### 13.35 Contractor's Appeal Rights

If any dispute shall arise under the terms of this Contract, the sole and exclusive remedy shall be the filing of a Notice of Appeal within thirty (30) calendar days of receipt of written notice of SCDHHS's action or decision which forms the basis of the appeal. Administrative appeals shall be in accordance with SCDHHS's regulations R. 126-150, et seq., Code of Laws of South Carolina (1976), Volume 27, as amended, and in accordance with the Administrative Procedures Act, §§ 1-23-310, et seq., Code of Laws of South Carolina (1976), as amended. Judicial review of any final SCDHHS administrative decisions shall be in accordance with § 1-23-380, Code of Laws of South Carolina (1976), as amended.

## 13.36 Loss of Federal Financial Participation (FFP)

The Contractor hereby agrees to be liable for any loss of FFP suffered by SCDHHS due to the Contractor's, or its subcontractors', failure to perform the services as required under this Contract. Payments provided for under this contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS in accordance with the requirements in 42 CFR 438.730.

#### 13.37 HIPAA Compliance

The Contractor shall comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the rules and regulations promulgated thereunder (45 CFR Parts 160, 162, and 164). The Contractor shall ensure compliance with all HIPAA requirements across all systems and services related to this contract, including transaction, common identifier, and privacy and security standards, by the effective date of those rules and regulations.

SCDHHS acknowledges that, while Contractor is a Business Associate under this contract, Contractor also separately qualifies as a covered entity as defined in the Privacy Rule. Accordingly, Contractor may use and disclose Protected Health Information for such purposes as are consistent with its status as a separate covered entity under the Privacy Rule.

## 13.38 National Provider Identifier

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The HIPAA Standard Unique Health Identifier regulations (42 CFR 165 Subparts A & D) require that all covered entities (health plans, health care clearinghouses, and those health care providers who transmit any health information in electronic form in connection with a standard transaction) must use the identifier obtained from the National Plan and Provider Enumeration System (NPPES).

Pursuant to the HIPAA Standard Unique Health Identifier regulations (42 CFR 165 subparts A & D), and if the provider is a covered health care provider as defined in 42 CFR §162.402, the provider agrees to disclose its National Provider Identifier (NPI) to SCDHHS once obtained from the NPPES. Provider also agrees to use the NPI it obtained from the NPPES, if applicable, to identify itself on all standard transactions that it conducts with SCDHHS.

#### 13.39 HIPAA Business Associate

Individually identifiable health information is to be protected in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as agreed upon in Appendix C.

# 13.40 Software Reporting Requirement

All reports submitted to SCDHHS by the Contractor must be in format accessible and modifiable by the standard Microsoft Office Suite of products or in a format accepted and approved by SCDHHS.

SPES

# 13.41 Employee Education About False Claims Recovery

If the Provider receives annual Medicaid payments of at least Five Million Dollars (\$5,000,000) the Provider must comply with Section 6032 of the Deficit Reduction Act (DRA) of 2005, Employee Education About False Claims Recovery.

IN WITNESS WHEREOF, SCDHHS and the Contractor, by their authorized agents, have executed this Contract as of the first day of April 2008.

SOUTH CAROLINA DEPARTMENT OF	
HEALTH AND HUMAN SERVICES	
"SCDHHS"	

"MHN PROVIDER"

"PROVIDER"

BY:	BY:		
	_		

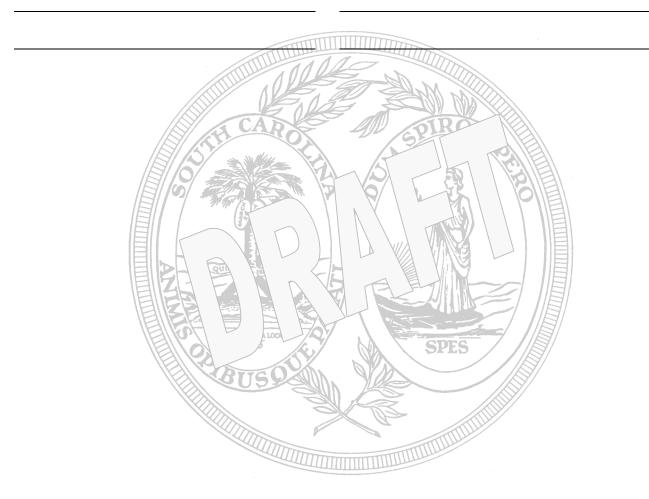
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Emma	Forkner
Directo	r

Authorized Signature

Print Name

WITNESSES: WITNESSES:



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# MEDICAL HOMES NETWORK DEFINITIONS, CONTRACT PROCESS AND STANDARDS

#### **Definitions**

The following definitions will used throughout this document:

- Care Coordination Services Organization (CSO): CSO shall be used to describe the entity providing the infrastructure to the Medical Homes Network.
- **Beneficiary:** An individual who is Medicaid eligible and meets the criteria to enroll in the Medical Homes Network program.
- **Member:** An individual who is Medicaid eligible and has enrolled in the Medical Homes Network program.
- Primary Care Physician (PCP): An individual physician or group medical practice who agrees to serve as the Member's primary physician, contribute to the development and implementation of the care treatment plan, and participate in quality of care initiatives and reviews. At this time, the following practice specialties are considered Primary Care: Family Medicine, General Practitioners, Pediatricians, Internal Medicine, OB/GYN, Federally Qualified Health Centers (FQHC), and Rural Health Clinics (RHC).

The Medical Homes Network (MHN) Program is a physician-driven service delivery system designed for Medicaid beneficiaries. Beneficiaries who choose to enroll in this program agree to utilize the primary care physician for their medical needs. This "partnership for care" enables the beneficiaries the comfort of knowing that they will receive coordinated medical services. Also, it is expected that beneficiaries enrolled in an MHN will utilize the emergency rooms less and have fewer hospitalizations due to enhanced primary care.

# The goals of the Medical Homes Network program are to:

- Establish medical homes for Medicaid beneficiaries to promote continuity of care and improve care coordination for beneficiaries.
- Emphasize wellness and prevention to improve quality of life.
- Provide 24-hour access to a licensed healthcare provider.
- Provide more intensive care coordination to members as needed.
- Reduce improper utilization of the emergency room for non-urgent healthcare.
- Reduce pharmacy costs.
- Better utilize Medicaid resources through increased patient monitoring, evidence based resources, and physician accountability.

 Enhance beneficiaries' ability to participate more fully in health care decisions.

#### THE CONTRACT PROCESS

This section will provide the information necessary for preparing to initiate a Medical Homes Network (MHN) contract with the DHHS. DHHS will furnish potential contractors with a copy of the model contract upon request. The model contract has been approved by the Centers for Medicare and Medicaid Services (CMS). The terms of the contract are established and are not negotiable.

DHHS will enter into a contract with any qualified Network that meets the DHHS standards for Medical Homes Networks. Incentives will be based on a shared savings model. SCDHHS will share documented cost savings with the Network. An independent actuary under contract with the department has developed the formula for the distribution of savings. Savings will be calculated by a "look back" at claims experience. The independent actuary will establish the appropriate case-mix adjustments for population comparison. The savings must be defined by a reduction in the cost of care of enrolled plan members, versus the cost of care of comparable un-enrolled Medicaid beneficiaries. If the Network does not achieve savings, SCDHHS will impose a penalty on the Network and a portion, if not all, of the prospective care coordination fee payments must be refunded to the SCDHHS. SCDHHS will conduct periodic cost reconciliation. At a minimum, cost reconciliation shall be conducted semi-annually. The shared savings formula is attached.

The Network will receive a prospective payment. The expenses or costs of operating the Network are to be paid out of the generated cost savings. The prospective payment is a Per Member Per Month Care Coordination/Management fee that is based on the number of enrolled members. The payment is prospective in that it is an advance against the Network's anticipated savings. Thus the Network may be required to pay back a portion, if not all, of this advanced payment if the Network does not generate savings. This is the only payment that DHHS will make. Any PMPM paid to the participating physicians must come out of this payment, as must operating costs. The only limit DHHS will put on how the Network spends the money will be the limitations/restrictions attached to Federal funds. The Network must submit its Physician PMPM formula and its shared savings formula to DHHS for approval. The Network will also be required to submit a cost report at the end of each contract year to account for how the money was spent.

SCDHHS will not contract with any individual and/or group of individuals having an outstanding debt with the agency. If any member of a group has an outstanding debt against SCDHHS, the entire group will be considered to have same.

The following Medicaid provider types may participate as a **Medical Homes- Primary Care Provider:** 

- Family Medicine
- General Practitioner
- OB/GYN
- Pediatrician
- Internal Medicine
- Federally Qualified Health Centers (FQHC)
- Rural Health Clinics (RHC)

Other provider types wishing to participate in a Medical Homes Network should petition/contact the local entity. A listing of current networks may be obtained by calling 803-898-4614.

The potential contractor should send a letter requesting consideration for participation in the MHN program. The letter should include a statement of purpose, brief company background to include ownership, corporate status, major shareholders and/or company officers, location of network, basic Network structure, and the name of the primary contact. The letter should be addressed to:

Director, Division of Care Management
South Carolina Department of Health and Human Services
P.O. Box 8206
Columbia, South Carolina 29202-8206

Upon receipt of this letter, DHHS will provide the applicant a copy of the MHN Application. This document details the entire application process. The applicant should develop/prepare a thorough written response to the application and should submit a total of six (6) copies (one original and five copies) of the response. This response becomes the potential contractor's official Application Packet and should be addressed to:

Team Leader, Department of Managed Care
South Carolina Department of Health and Human Services
P.O. Box 8206
Columbia, South Carolina 29202-8206

#### MEDICAL HOMES NETWORK STANDARDS

In order to ensure that services provided to Medicaid beneficiaries are of the highest quality, the following standards have been developed to guide the formation and development of Medical Homes Networks (MHN) within the South Carolina Medicaid program. For simplicity, SCDHHS will refer to the management entity associated with the Network as a Care Coordination Services Organization (CSO). These standards detail the requirements for (1) the Care Coordination Services Organizations, and (2) Information Technology Systems. Preliminary contract deliverables and sanctions are also included.

# Attachment II Information Technology Standards For Medical Home Networks Attachment III Deliverables and Sanctions

#### ATTACHMENT I

# ENROLLMENT STANDARDS FOR MEDICAL HOMES NETWORK CARE COORDINATION SERVICE ORGANIZATIONS

DHHS will contract with a Care Coordination Service Organization (CSO) for the purpose of the development and maintenance of a Medical Homes Network. The Network shall be defined as the participating physician practices, any advisory boards, The CSO shall be the designated agent for the Network. Care and the CSO. Coordination Service Organizations (CSO) are to be experienced, responsive, responsible, and financially sound organizations that provide administrative support to the Network and the participating primary care practices. If the Network so chooses, it may disburse a Per Member Per Month (PMPM) Care Coordination fee for each enrolled member to each participating provider. The PMPM will be paid by the Network. The Network shall develop a formula for the distribution of the PMPM which shall be approved by SCDHHS. The State intends to share any documented cost savings with the network through the CSO by utilizing an agreed-upon formula established by independent actuaries contracted by the State. The CSO will be responsible for dividing the Network's share between the participating practices and the CSO, based upon the agreement established between the CSO and the practices. The CSO will be responsible for components and services as follows:

- Formal Care Coordination and Case Management;
- Service Utilization Management/Track services provided to members;
- Member Education;
- Disease Management;
- Provider Education and training on evidence-based medicine and Best Practice protocols;
- Pharmacy Management to include, but not limited to: Benefit Management Oversight, Prior Authorization and Clinical Risk Identification;
- Exception and performance tracking and reporting;
- Outcomes measurement and data feedback; and
- Distribution of any cost savings.

The Scope of Work the CSO is expected to perform consists of these components:

- 1. Development, maintenance and expansion of a network of physicians that will assume the responsibility of providing medical homes for Medicaid beneficiaries in their respective service areas. The CSO is expected to provide a sufficiently developed infrastructure to support the member practices in the management of the medical and health care needs of members to assure that all medically necessary services are made available in a timely manner. This infrastructure should include, at a minimum:
  - A protocol for care coordination/case management to include:
    - Proposed care coordination staffing.
    - Proposed methodology for defining which patients will receive care coordination services. Patients who are considered "high utilizers" and/or non-compliant must be targeted for care coordination.
    - o Proposed procedures to follow up with patients admitted to the

hospital, seen at the emergency room, or by some other medical professional.

- Proposed procedures for addressing non-compliant members.
- Disease Management initiatives based on the network's demographics, including protocols for at least two (2) disease states.
- Pharmacy Oversight and Management.
- 24-hour call service/Help Line/Nurse Line that is staffed 24 hours per day, 7 days per week
- 2. Assistance to the MHN to ensure their ability to provide:
  - Care Coordination and Case Management
  - Disease Management
  - Pharmacy oversight and management
- 3. Demonstrate budget neutrality or cost savings for services to beneficiaries in the plan.
- 4. Management of the medical and health care needs of members to assure that all medically necessary services are made available in a timely and cost efficient/effective manner.
- 5. Monitoring and follow-up on care provided by other medical service providers for diagnosis and treatment, to include externally referred services.
- 6. Ensurance that the participating PCPs meet the following standards:
  - A. The practices must provide primary care and patient care coordination services to each member.
  - B. The practices must provide or arrange for Primary Care coverage for services, consultation or referral, and treatment for emergency medical conditions, twenty-four (24) hours per day, seven (7) days per week.
  - C. There must be prompt (within one hour) access to a qualified medical practitioner who is able to provide medical advice, consultation, and authorization for service when appropriate. PCPs must have at least one telephone line that is answered by office staff during regular office hours. (Use of an automated system to answer the phone is acceptable as long as patients are able to access a live person through one of the automated options.)
  - D. PCPs must provide members with an after-hours telephone number. The after-hours number may be the PCP's home telephone number, an answering service, etc. The after-hours telephone number must be listed in the member's handbook. Changes to the after hours number should be reported to the Care Coordination Services Organization.
  - E. The practices must provide preventive services as defined by the network advisory board.
  - F. The practices must offer general patient education services to all members and potential members as well as disease management services to members for whom the services are appropriate.
  - G. MHN PCPs must establish and maintain hospital admitting privileges or enter into an arrangement with another physician or group practice for the management of inpatient hospital admissions of MHN members.
  - H. The practices will assist the member by providing systematic, coordinated care and will be responsible for all referrals for additional medically necessary care to other health care providers.
  - I. The practices will be required to follow the recommended Early and Periodic

- Screening, Diagnosis, and Treatment (EPSDT) screening schedules, as required by the Centers for Medicare and Medicaid Services (CMS).
- J. The practices will be required to utilize the following standards for Appointment Availability:
  - Emergency care immediately upon presentation or notification
  - Urgent care within 48 hours of presentation or notification
  - Routine sick care within 3 days of presentation or notification
  - Routine well care within 45 days of presentation or notification (15 days if pregnant)
- K. The practices will be required to utilize the following standards for office visit times:
  - Walk-ins within two hours or schedule an appointment within the standards of appointment availability listed above
  - Scheduled appointment within 45 minutes
  - Life-threatening emergency –must be managed immediately

The CSO must be an established entity with its own tax ID number. Organizations interested in participating in a MHN should call the SCDHHS Division of Care Management at 803-898-4614 to inquire about the contractual arrangements.

NOTE: A CSO that also operates a Medicaid Managed Care Organization (MCO) in South Carolina will not be allowed to conduct business as both a CSO and an MCO within the same county.

#### Minimum Criteria

A CSO/Network must meet the following criteria and be approved in order to be considered for participation in the Medical Homes Program. The identified protocols must also be submitted and approved by SCDHHS.

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- 1. Must demonstrate experience as a Care Coordination Services Organization in a Medicaid managed care environment.
- 2. Demonstrated evidence of successful development of physician networks.
- 3. Demonstrated network and physician management to include:
  - Provider satisfaction data,
  - Cost effectiveness data, and
  - Quality data (member satisfaction and documented Quality Improvement Program).
- 4. Appropriate credentials and Medicaid-specific experience of all staff personnel (either current to be documented in resumes or to be required and documented in job descriptions) dedicated to the program.
- 5. Demonstrated utilization management abilities to include:
  - Referral Management,
  - Drug utilization review, and
  - Practice guidelines.
- 6. Demonstrated ability to engage the target populations (PCPs and Beneficiaries/Members) resulting in provider and member satisfaction and to facilitate increased coordinated access to care.
- 7. Demonstrated ability to coordinate with and educate health care providers and to sustain participation and coordination with these providers. Submit documentation of education provided to the providers over the past 5 years. Submit evidence of provider retention over the past 5 years; provider retention must be at least 80%.
- 8. Demonstrated ability to identify and address quality of care issues (e.g., identify gaps between recommended prevention and treatment and actual care provided to members).
- 9. Demonstrated ability to apply nationally recognized, evidence-based clinical guidelines in the application of services.
- 10. Demonstrated ability to educate MHN members and/or their caregivers regarding child development, childhood diseases, and any particular health care condition and the needs brought about by health problems, with the goal of increasing MHN member and/or caregiver understanding and to enhance their effectiveness in self-care. Submit examples of education provided to the members over the past 5 years. Submit all materials used, description of activities, etc. conducted with members over the past 5 years. Include both English and Spanish versions.
- 11. Demonstrated ability to manage various health and any co-morbid conditions.
- 12. Demonstrated ability to assure ongoing monitoring and evaluation of MHN member health status. Submit detailed descriptions of activities implemented to address health status issues and the resulting effects in acute care costs.
- 13. Demonstrated ability to assure ongoing monitoring and evaluation of MHN provider service utilization and progress on program outcomes. Submit sample reports.
- 14. Demonstrated ability to manage and analyze MHN member and MHN provider demographic, utilization, and cost data. Submit sample reports.
- 15. Demonstrated ability to comply with current HIPAA regulations.
- 16. Demonstrated financial soundness. Each Network must provide assurances that the State of South Carolina, SCDHHS or Medicaid beneficiaries will not be liable for the Network's debt if the Network becomes insolvent. The Network must provide evidence of a reserve account with a federally guaranteed financial institution. Additional Fiscal Requirements are found in the MHN Application.
- 17. Must provide management team's credentials and background summaries.
- 18. Demonstrated information technology proficiency to include
  - Enrollment tracking,
  - Re-determination tracking,
  - Data support for utilization management and case management services, and

• Ownership of or a contractual relationship with a data warehouse or central database with the ability to provide monthly, yearly, and ADHOC reports to the advisory board, individual physicians, and SCDHHS.

See Attachment II for more detailed specifications on IT/data system requirements.

19. Demonstrated care management protocols to include:

Staffing criteria,

- Procedures for identifying patients in need of care management,
- Ability to work with families and other community supports/providers,

Ability to engage members in care management,

- Care manager access protocols (Please describe how a member accesses the care manager; i.e., assignment, request, chronic condition, missed appointment, etc.),
- Care management protocols for specific diseases, and

Patient education methods and capacities.

- NOTE: The CSO may operate its 24-hour Help Line outside of South Carolina. However, in anticipation of care coordination services that must be delivered face-to-face, the CSO will be expected to employ or contract with local Care Coordinators.
- 20. Demonstrated ability to begin full operation within 30 days of receiving a contract from DHHS.
- 21. None of the primary parties involved in the Network or any affiliated personnel can have any outstanding debt with SCDHHS.
- 22. In establishing/building its provider network, the CSO/Network must target medically underserved areas of South Carolina.
- 23. A CSO shall not be a subsidiary of a parent company currently engaged in a managed care contract with South Carolina Medicaid.
- 24. Protocols addressing the following:
  - A. A protocol to ensure regular evening and weekend office hours to accommodate the needs of the members. This must be submitted within six (6) months of the Network beginning operations.
  - B. A protocol to provide medical homes for Medicaid patients that do not have a medical home and/or use the Emergency Room as their PCP.
  - C. A protocol to educate Medicaid beneficiaries on appropriate use of the ER and other medical services and to divert members from the emergency room to urgent care or primary care when appropriate.
  - D. A protocol to control, monitor and follow-up on care provided by other medical service providers for diagnosis and treatment.
  - E. A protocol for furnishing providers and members with evidence-based information and resources to support optimal health management.
  - F. A protocol that emphasizes and defines prevention and self-care
  - G. A data management, reporting and feedback process with Network members to track exceptions and performance, to improve health outcomes, document cost effectiveness, including monthly patient profile reports. DHHS will provide data to the Network and the providers, which detail the claims activities on all enrolled members.
  - H. A protocol on maintaining Medicaid eligibility, to include providing assistance to members in completing the eligibility renewal process to reduce the percent of members whose eligibility is interrupted due to failure

to respond properly during the re-determination process.

- I. A protocol to educate new and potential members on the enrollment process.
- J. A protocol to ensure the cultural competency of the Network.
- K. A protocol for involving the participating physicians in the oversight and direction of initiatives for the network to include:
  - ✓ Establishing best practices
  - ✓ Monitoring overall quality of care within the network
  - ✓ Monitoring overall network costs to Medicaid
  - ✓ Utilization of data management to improve healthcare for the state

In order to demonstrate the various skills and abilities detailed above, the interested CSO must answer a series of questions addressing the following:

- 1. Organizational experience;
- 2. Provider education and interface;
- 3. Beneficiary Help Lines which are staffed 24-hour per day/7 days per week and 24-hour/7 day access to the practice (This may be accomplished through an answering service. An answering machine that merely directs the members to the ER is not acceptable.):

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- 4. Care Coordination system;
- 5. Care Coordination staff;
- Provider engagement;
- 7. Disease Management system;
- 8. Quality Assessment and Improvement program;
- Evaluation:
- Shared savings distribution formula;
- 11. Care Coordination Per Member Per Month distribution formula;

- 12. References;
- 13. Data systems;
- 14. Protocols:
- 15. Previous External Quality Review experience; and
- Enhanced care coordination to special populations.

#### ATTACHMENT II

#### INFORMATION TECHNOLOGY STANDARDS FOR MEDICAL HOME NETWORKS

#### 1. General Characteristics

The MHN Information Technology (IT) System must be sufficiently sophisticated enough to support the many functions of the MHN program. It will contain highly confidential data whose handling is subject to various laws and regulations. The data sets will tend to be large. Although the ultimate responsibility for patient care remains with the physician or other provider, lost or inaccurate data can impede the ability of the MHN to support the provision of optimal care by the provider.

The MHN IT System must meet the following general characteristics:

- Compliance with Law and Regulations The MHN's data system must comply with all applicable laws and regulations for the handling of confidential health information. This includes the requirements of HIPAA for Protected Health Information; HIPAA requires assurance of privacy and security, and mandates the use of certain formats for data transfers, among other requirements.
- <u>Security</u> MHN IT systems must be secure from compromise by internal and external threats.
- Accuracy The data system must maintain data accurately and without corruption.
- <u>Stability and Reliability</u> The data system must be stable, not subject to sudden failures or unreliable behavior.
- Robustness The data system must have the capacity to handle very large data sets without suffering from undue degradation of performance.
- Redundancy At a minimum, the data sets must be backed up on a scheduled basis, and the backup copies stored on separate media in a separate geographic location from the main data center.

# 2. Systems

The optimal system will provide access to data via secure direct client access and secure web-based access to the data. The system must be able to import, store, process, and export large volumes of data in an acceptable amount of time. Response times for online query will be sub-second. Interface speeds will be in accordance with current industry standards. The system's architecture must be kept current with industry standards.

Please note that all interface layouts and EDI communications protocols will be dictated by DHHS. All EDI communications must be encrypted to meet or exceed HIPAA standards.

In general, MHN programs will require two different types of systems: Transaction

<u>Systems</u>, which manage the day-to-day operations of the MHN program with real-time interaction; and <u>Reporting and Analysis Systems</u>, which provide the reports for monitoring and analyzing the performance of the program, recognizing trends, and identifying problems and opportunities.

# **Transaction Systems**

Transaction systems allow quick access to needed data for support of daily tasks. MHNs require the following Transaction Systems:

# 1. Enrollment System

The MHN must be able to accurately track which beneficiaries are enrolled in the program at any given time. The Enrollment System must support storage and retrieval of at least the following information for each Member:

Name
Medicaid ID #
Address
Date Of Birth
Primary Physician
Enrollment Status (Enrolled, Disenrolled, etc.)
Date of Enrollment
Date of Disenrollment

# 2. Medical Management System

The Medical Management System must support, at a minimum, the following functions:

# a. Referral Management

The Primary Care Case Management (PCCM) model embodied in the MHN program requires that members receive a referral from their primary physician for non-emergent care from other providers. Therefore, the MHN must have an information system that can record, track, and verify referrals in a real time manner. The system must also support the functions of preauthorization and post-authorization in a similar way.

The Referral System must record, at a minimum:

- √ Name of the member being referred
- ✓ Member's Medicaid ID
- ✓ Identity of the referring doctor
- ✓ Identity of the provider being referred to
- ✓ Condition or diagnosis of the patient for which referral is sought
- ✓ Service being requested
- ✓ Time limit or number of visits authorized
- ✓ Referral or authorization identifying number

The Referral System must have functionality that immediately identifies attempted referrals that are duplicates of existing still-valid referrals, or that violate medical policy in some way (referrals to providers who are not Medicaid providers, for example).

# b. Care Management

Once high-risk, high-utilizing, or vulnerable patients are identified, the MHN program is responsible for monitoring the care of such patients. For this, a system is required that supports ongoing care management by clinical personnel.

The Care Management System must include at least the following functions:

- Intake the ability to enroll a new patient into the Care Management process. Information collected here must include patient demographics, diagnoses and conditions, treating physicians, medications, a current problem list, and contact information for all relevant providers and family.
- Contact Recording the ability to record the relevant information regarding each contact with the patient, their providers, or others relevant to the case. Contact recording must be made simple and fast, so that it can proceed in real time, during a telephone call, for example. Retrieval of records from prior contacts must be simple, fast, and intuitive.
- Reminders the ability to prompt the care manager with a pre-recorded reminder to perform a task (such as, call the patient) at some previously decided interval (such as, one week from the last contact).
- Best Practice Protocols the ability to call up relevant clinical protocols representing best practices for the management of both common and complex diseases.
- c. Drug Utilization Management

The MHN program must support optimal regimens of medications for members. Some mechanism must be provided for educating physicians as to the most clinically effective and cost effective drugs for each condition. At a minimum, the MHN program must provide online access for physicians to the drug education information it has developed.

# d. Quality Management

The MHN program must assure and improve the quality of care while it is working to reduce unnecessary costs. The information system must support quality management functions by:

- Tracking industry-standard quality measures, such as HEDIS;
- Tracking complaints by providers and members, with recording of the process of investigating the complaint, as well as recording the result of the investigation and any corrective actions taken; and
- 3. Tracking member satisfaction and provider satisfaction measures.

#### e. Patient Education

The MHN program supports healthy behaviors by members and helps educate them on relevant aspects of their medical conditions, medications, planned tests or procedures. At a minimum, the MHN information system makes effective patient education materials available online for physicians and/or patients.

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# 3. Provider Service System

The MHN program requires the recruitment and education of providers, and collaboration with and among them. The Provider Service System must include the following functions, at a minimum:

- a. Contact Management storage and retrieval of provider contact information, plus tracking of all contacts with a provider in the course of recruitment, contracting, inservice training, education, and problem resolution.
- b. Practice Management Information storage and retrieval of locations, office hours, age restrictions, etc.
- Contract Information storage and retrieval of information on the provider's contracts with SCDHHS and with any MHN Care Coordination organization.
- d. Credentialing Information storage and retrieval of information on provider's medical specialty, licensure, malpractice insurance, etc.

## 4. Financial System

The MHN program will potentially handle significant sums of Medicaid funds, in administrative fees and shared savings payments, and must possess adequate financial systems for the purposes of accounting, payments, audit and control. In addition, the MHN program may pay out performance bonuses to providers, and must have sufficiently powerful and flexible financial systems to calculate, pay, and account for such bonuses. SCDHHS anticipates that the MHN program will become the claims processor for the physicians in the network: receiving claims (electronically and via hard copy), processing claims, and paying claims. The financial system must be able to expand to easily accommodate this function without causing any disruption to the participating providers.

The MHN Financial System must, at a minimum, include the following functions:

- Accounting
- Accounts Payable
- Accounts Receivable
- Provider accounting for calculation and payment of performance bonuses

# Reporting and Analysis Systems

MHNs must be able to produce a wide range of reports for both internal and external use, and be able to perform sophisticated analyses on very large sets of claims and enrollment data in order to optimally support the provision of quality, cost-effective care by contracted providers. A Reporting and Analysis System will perform these functions.

The MHN Reporting and Analysis System will have the following design:

- 1. The Data Warehouse uses an industrial-strength relational database, typically based on Structured Query Language (SQL).
- 2. The Data Warehouse has strong capabilities for data import and data export. It will likely be receiving data from multiple distinct sources, and must be able to output data into a variety of industry standard formats, to enable end-user presentation and manipulation in industry standard office productivity applications such as spreadsheets and PC databases.
- The Data Warehouse contains all of the relevant data needed for the MHN's reporting and analysis function, receiving data feeds from, at a minimum, Enrollment, Claims, Medical Management, and Financial Systems data. Data

in the Data Warehouse should include, at a minimum:

Member demographics

Claims information, including at least:

Date of Service

Service/Medication Provided

Quantity of Service/Medication

Provider of Service

Place of Service

Diagnosis

Payment

Referring/Prescribing Provider

Referral/Authorization Code

Date Paid

Claim Identification Number

**Enrollment/Disenrollment Dates** 

Primary Care Provider

Primary Care Provider information

Information on other providers

Referral/Authorization data

Case Management data

**Drug Utilization Data** 

Quality Management data

Financial data, including information on performance bonuses paid

The MHN Reporting and Analysis System will include strong tools for both reportgeneration and analysis of patterns and trends. The Reporting function must include, at a minimum:

- 1. A comprehensive set of standard reports, including, at a minimum:
  - a. Enrollment reports, including monthly reports on currently enrolled, newly enrolled, and disenrolled beneficiaries.
  - b. Referral/authorization reports, including monthly reports on members' referred/authorized for services.
  - c. Utilization reports, including monthly reports on hospital usage, Emergency Room usage, and medication usage.
  - d. Case management reports, including monthly reports on members with target diagnoses, members in case management, and utilization by target disease.
  - e. Quality management reports, including tracking of industry-standard measures such as HEDIS, plus member satisfaction and provider

satisfaction.

- f. Health maintenance reports, including quarterly reports on members who have not had recommended health maintenance interventions (such as Child Health Checkup, or Diabetic Eye Exam) within prescribed or recommended time frames.
- g. Provider profiling, report card, and performance bonus reports.

Reports must have the ability to be run on a "to be determined", schedule.

- 2. In addition to a comprehensive set of standard reports, the data system should include strong tools for generating ad hoc reports as the need arises, including, at a minimum:
  - A user interface sufficiently straightforward that it is usable by nontechnical end users;
  - b. Ability to output results as tables and/or graphs of various types, as chosen by the user;
  - Ability for the user to make comparisons, sort lists, drill down, roll up/combine, and identify results that exceed or fall below some threshold; and
  - d. Ability to import and export data in various common formats for use in common office productivity tools such as spreadsheets and PC databases.

#### ATTACHMENT III

#### **DELIVERABLES AND SANCTIONS**

The Network shall, at a minimum, submit the following to SCDHHS:

- > Definition of the preventive services to be offered by each participating practice, later than six (6) months after commencing operations or the execution/renewal of the contract.
- > A monthly log of all after-hours calls from members to the practice and to the Help Line and the disposition of those calls.
- > An electronic monthly listing of PCPs participating in the Network.
- > On a quarterly basis, the MHN's Grievance and Appeal Logs with Summary Information.
- > A report of the participating PCPs' level of compliance with the practice requirements to be submitted every six (6) months.
- > The disease states which the Network intends to target, including the interventions to be used and the anticipated outcomes no later than six (6) months after commencing operations.
- > Documented contact with each new member within three (3) months of enrollment.
- > The identified quality of care issues within the Network's area and a Plan of Action to address these issues within six (6) months after commencing operations or the execution/renewal of the contract.

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The State shall employ a variety of sanctions including, but not limited to, the following:

- Withholding of Network PMPM;
- Monetary penalties;
- Suspension of enrollment privileges;
   Suspension of marketing activities;

Termination of Contract



#### APPENDIX B

## **Medical Homes Network Cost Savings Formula**

Reimbursement to the Medical Homes Network (the advisory Board and the Care Coordination Services Organization [CSO]) will be based on a shared savings model. The Network will be paid a prospective care coordination fee per member per month. In order to determine the cost savings achieved by a Medical Homes Network, the cost of enrolled Network members will be accumulated on a quarterly basis and will be compared to the cost of covering those same members in a fully insured Medicaid Managed Care Organization (MCO).

Using eligibility and enrollment data, each Network enrollee's member months will be calculated and placed into an age and sex cell developed for Medicaid HMO payment purposes. Member months will be accumulated by age and sex cells and then be applied against the applicable MCO risk adjusted rates to develop the "Medicaid Upper Payment Limit". The "Medicaid Upper Payment Limit" will also include "kicker" payments made for deliveries and births. The risk adjusted "Medicaid Upper Payment Limit" will then be compared against the Medicaid claim expenditures of Network enrollees (including any prospective care coordination fee payments paid to the Care Coordination Services Organization) to determine whether the Network achieved savings. Claim expenditures incurred by Network enrollees will include only those expenditures that are covered under the Medicaid HMO service package (including an adjustment for claims incurred but not reported).

If the Network realizes savings, then the South Carolina Department of Health and Human Services (SCDHHS) will provide an incentive and will reimburse the Network 50% of the savings realized. However, this payment cannot exceed five percent (5%) of the fee for service payments incurred by the network enrollees. The Network's CSO will be responsible for dividing the Network's share of the savings between the participating practices and the CSO, based on the agreement established between the CSO, the Advisory Board, and the participating practices. If the Network does not achieve savings, SCDHHS will impose a penalty on the Network and a portion, if not all, of the prospective care coordination fee payments must be refunded to the SCDHHS. Only the prospective care coordination fee payments are at risk since the SCDHHS will continue to directly reimburse the providers on a fee for service basis.



#### HIPPA BUSINESS ASSOCIATE TERMS

## A. Purpose:

The South Carolina Department of Health and Human Services (COVERED ENTITY) and CONTRACTOR (Business Associate) agree to the terms of this Appendix for the purpose of protecting the privacy of individually identifiable health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) in performing the functions, activities, or services for, or on behalf of, COVERED ENTITY as specified in the Contract between the parties.

- B. Definitions (Terms used, but not otherwise defined, in this Section shall have the same meaning as those terms in the HIPAA Privacy Rule.
  - Business Associate. "Business Associate" shall have the same meaning as the term "business associate" in 45 CFR § 160.103 (2002)
  - 2. Covered Entity. "Covered Entity" shall mean SCDHHS.
  - 3. Individual. "Individual" shall have the same meaning as the term "individual in 45 CFR § 164.501 (2002) and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502 (2002)
  - 4. Privacy Rule. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E (2002)
  - 5. Protected Health Information. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR § 164.501 (2002), limited to the information created or received by Business Associate from or on behalf of Covered Entity.
  - 6. Required By Law. "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR § 164.501 (2002).
  - 7. Secretary. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.
  - 8. Security Standard shall mean the Security Standards at 45 C.F.R. Part 160 and Part 164, as may be amended.
  - 9. Electronic PHI shall have the same meaning as the term "electronic protected health information" in 45 C.F.R. § 160.103.

10. Security Incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interface with system operations in an information system or its current meaning under 45 C.F.R. § 164.304.

# C. Business Associate Agrees to:

- 1. Not use or disclose PHI other than as permitted or required by the Contract or as Required By Law.
- 2. Use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for in this Appendix.
- 3. Mitigate to the extend practicable, any harmful effect know to BUSINESS ASSOCIATE if BUSINESS ASSOCIATE uses/disclosures PHI in violation of this Appendix.
- 4. Report to COVERED ENTITY any use or disclosure of the PHI not provided for in this Appendix of which it becomes aware.
- Ensure that any agent/subcontractor to whom it provides PHI agrees to the same restrictions/conditions that apply to the BUSINESS ASSOCIATE in this Appendix.
- 6. If the BUSINESS ASSOCIATE has PHI in a Designated Record, provide access at the request of COVERED ENTITY, and in the time and manner designated by COVERED ENTITY, to PHI in a Designated Record Set, to COVERED ENTITY or, as directed by COVERED ENTITY, to an Individual in order to meet the requirements under 45 CFR § 164.524.
- 7. If the BUSINESS ASSOCIATE has PHI in a Designated Record Set, make any amendment(s) to PHI in a Designated Record Set that the COVERED ENTITY directs or agrees to pursuant to 45 CFR § 164.526 at the request of COVERED ENTITY or an Individual, and in the time and manner designated by COVERED ENTITY.
- 8. Make internal practices, books, and records, including policies and procedures and PHI, relating to the use and disclosure of PHI received form, or created or received by BUSINESS ASSOCIATE on behalf of, COVERED ENTITY available to the COVERED ENTITY, or at the request of the COVERED ENTITY to the Secretary, in a time and manner designated by the COVERED ENTITY or the Secretary, for purposes of the Secretary determining COVERED ENTITY'S compliance with the Privacy Rule.

- Document such disclosures of PHI and information related to such disclosures as would be required for COVERED ENTITY to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.
- 10. Provide to COVERED ENTITY or an Individual, in time and manner designated by COVERED ENTITY, information collected in accordance with Section C.9 of this Appendix, to permit COVERED ENTIY to respond to a request by an Individual for an accounting of disclosure of PHI in accordance with 45 CFR § 164.528.
- 11. Business Associate understands and agrees that, should SCDHHS be found in violation of the HIPAA Privacy Rule due to business associate's material breach for this Section, business associate shall be liable to SCDHHS for any damages, penalties and/or fines assessed agains SCDHHS as a result of business associate's material breach. SCDHHS is authorized to recoup any and all such damages, penalties and/or fines assessed against SCDHHS by means of withholding and/or offsetting such damages, penalties, and/or fines against any and all sums of money for which SCDHHS may be obligated to the business associate under any previous contractual relationship between the business associate and SCDHHS, the amount to cover such damages, penalties and/or fines shall be due from business associate immediately upon notice.

# D. Permitted Uses and Disclosures by BUSINESS ASSOCIATE

- 1. Except as limited in this Appendix, BUSINESS ASSOCIATE may use PHI to perform functions, activities, or services for, or on behalf of, COVERED ENTITY as specified in the Contract noted in A. provided that such use would not violate the Privacy Rule if done by COVERED ENTITY or the COVERED ENTITY's minimum necessary policies and procedures. Unless otherwise permitted in this Appendix, in the Contract noted in A. above or as Required by Law, BUSINESS ASSOCIATE may not disclose or re-disclose PHI except to COVERED ENTITY.
- Except as limited in this Appendix, BUSINESS ASSOCIATE may use or disclose PHI for the proper internal management and administration of the BUSINESS ASSOCIATE or to carry out the legal responsibilities of the Business Associate, as needed for BUSINESS ASSOCIATE to provide services to COVERED ENTITY under the above noted Contract.
- 3. Except as limited in this Appendix, BUSINESS ASSOCIATE may use

- PHI to provide Data Aggregation services to COVERED ENTITY as permitted by 42 CFR § 164.504 (e)(2)(i)(B).
- 4. BUSINESS ASSOCIATE may use PHI to report violations of law to appropriate Federal and State authorities, consistent with § 164.502 (j)(1).

#### E. COVERED ENTITY Shall:

- 1. Notify BUSINESS ASSOCIATE of any limitation(s) in its notice of privacy practices of COVERED ENTITY in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.
- Notify BUSINESS ASSOCIATE of any changes in, or revocation of, permission by Individual to use to disclose PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.
- Notify BUSINESS ASSOCIATE of any restriction to the use/disclosure of PHI that COVERED ENTITY has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use/disclosure of PHI.
- Not request BUSINESS ASSOCIATE to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by COVERED ENTITY.

#### F. Term and Termination

- 1. The terms of this Appendix shall be effective immediately upon award of the Contract noted in I. And shall terminate when all of the PHI provided by COVERED ENTITY to BUSINESS ASSOCIATE, or created or received by BUSINESS ASSOCIATE on behalf of COVERED ENTITY, is returned to COVERED ENTITY, or, if it is infeasible to return PHI, protections are extended to such PHI in accordance with the termination provisions in this Section.
- 2. Upon COVERED ENTITY's knowledge of a material breach by BUSINESS ASSOCIATE, COVERED ENTITY shall:
  - a. Provide an opportunity for BUSINESS ASSOCIATE to cure the breach or end the violation and terminate the Contract if BUSINESS ASSOCIATE does not cure the breach or end the violation within the time specified by COVERED ENTITY; OR

- b. Immediately terminate the Contract if BUSINESS ASSOCIATE has breached a material term of this Appendix and cure is not possible; OR
- c. If neither termination nor cure is feasible, COVERED ENTIY shall report the violation to the Secretary.

#### 3. Effect of Termination

- a. Except as provided in paragraph (2) below, upon termination of the Contract, for any reason, BUSINESS ASSOCIATE shall return all PHI received from COVERED ENTITY, or created or received by BUSINESS ASSOCIATE on behalf of COVERED ENTITY. This provision applies to PHI in the possession of subcontractors or agents of Business Associate. BUSINESS ASSOCIATE shall retain no copies of PHI.
- b. In the event that BUSINESS ASSOCIATE determines that returning the PHI is infeasible, BUSINESS ASSOCIATE shall provide to COVERED ENTITY notification of the conditions that make return infeasible. Upon mutual agreement of the parties that return of PHI is infeasible, BUSINESS ASSOCIATE shall extend the protections of this Appendix to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return infeasible, for so long as BUSINESS ASSOCIATE maintains such PHI.

# G. Security Compliance

This Section shall be effective on the applicable enforcement date of the Security Standards. Business Associate agrees to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives. maintains, or transmits on behalf of the Covered Entity, and will require that its agents and subcontractors to whom it provides such information Further, Business Associate agrees to comply with do the same. Covered Entity's security policies and procedures. Business Associate also agrees to provide Covered Entity with access to and information concerning Business Associate's security and confidentiality policies. processes, and practices that affect Electronic PHI provided to or created by Business Associate pursuant to the Agreement upon reasonable request of the Covered Entity. Covered Entity shall determine if Business Associate's security and confidentiality practices, policies, and processes comply with HIPAA and all regulations promulgated under HIPAA. Additionally, Business Associate will immediately report to Covered Entity any Security Incident of which it becomes aware.

#### H. Miscellaneous

- 1. A reference in this Appendix to a section in the Privacy Rule means the section as in effect or as amended.
- 2. The Parties agree to amend this Appendix as necessary to comply with HIPAA and other applicable law.
- 3. The rights and obligations of BUSINESS ASSOCIATE under Section F.3. shall survive the termination of the Contract.
- 4. Any ambiguity in this Appendix shall be resolved to permit COVERED ENTITY to comply with the Privacy Rule.

